NEW CLIENT INTAKE FORM

Name of Person Completing This Form

Relationship to Client

Section 1 – General Information

Name		Nickname	
Preferred Pronouns		DOB	
Age		Gender	
Address			
Phone Number		Email Address	

Section 2 – Referral

Referred By		Phone Number	
Primary Concerns			

Section 3 – Medical History

Current Health Issues: (check all that apply)

- ☐ Hypertension
- ☐ Thyroid
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Seizures
- ☐ Head Injury

Other Medical Diagnoses

PCP

Phone Number

Section 4 – Behavioral Health History

Prior Diagnosis

Hospitalization History *(Location, Date, Reason, Outcome)*

PHP / IOP History *(Location, Date, Reason, Outcome)*

Therapist

Phone Number

Psychiatrist

Phone Number

Medications

Previous Medication Trials

Section 5 – Emergency Contact

Name

Relationship to Client

Address

Phone Number

Email Address

Section 6 – Insurance

Primary Insurance:

Insurance Carrier

Policy Holder Name

Policy Number

Group Number

Secondary Insurance:

Insurance Carrier

Policy Holder Name

Policy Number

Group Number

Section 7 – Pharmacy

Pharmacy Name

Phone Number

Location

Patient / Guardian Signature

Date