

# Client Intake Form

## **Basic Information:**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Sex:            M            F      Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

## **Phone Numbers:**

Home: \_\_\_\_\_ Work: \_\_\_\_\_ Fax: \_\_\_\_\_

Mobile: \_\_\_\_\_ E-mail: \_\_\_\_\_

Referred By: \_\_\_\_\_

## **Professionals you are/have worked with:**

Physician: \_\_\_\_\_

Psychiatrist: \_\_\_\_\_

Therapist: \_\_\_\_\_

## **Diagnosis:**

Primary Diagnosis: \_\_\_\_\_

Other Diagnosis: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## **Current Medications:**

Condition	Medication	Dose	Doctor	When Started

## **Marital Status:**

Single            Married            Divorced            Separated            Widowed

**Work Record:**

Employer	Position	Dates Employed

**Family and Relationships:**

Please list all of the people living in your household, including siblings, step children, other relatives, foster children, friends, step parent, etc:

Name	Relation	Age	Highest Grade Finished	Occupation

List siblings not living with you:




Give an example of how each of these impacts your daily life now.

Inattention:

Lose track of conversations

Forget things

Make careless mistakes

Easily distracted

Other:

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Hyperactivity/Impulsivity:

Impatient when others aren't

Blurt out answers

Interrupt or intrude on others

Easily distracted

Other:

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Socialization/Relationship Difficulties:

Have few friends

Wallflower in public

Make careless mistakes

Easily distracted

Other:

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Organizational Difficulties:

Home/workplace a mess

Lose things often

Often late completing tasks

Many things on to-do list

Other:

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