
**Client Intake Form**

**Client Name _____Preferred Name & Pronoun_____**

**How did you hear about us? _____ DOB _____ Age: ___ Today's Date _____**

**Social Security Number ____-___-_____** *(for insurance purposes)* **Relationship Status: _____**

**Contact # _____ (**h/w/cell**) Alt # (optional) _____**

**Address _____**

**How did you hear about us?** Online Search____ Physician _____ PT _____ Counselor _____

**Present Partner's Name _____ Number of months/years together _____**

**Emergency Contact: Name _____ Phone # _____Relation: _____**

**Do you have any children? __Yes __ No If yes, please list their names, ages, and where they live.**

_____

_____

**Client's Employer: _____ Address: _____**

**Position: _____ Years Employed: _____**

**Client's Education – years of schooling _____ College or University: _____**

**Areas of Study: _____ Degree(s): _____**

**If Client is a Minor:**

**Father's Name: _____ SSN: _____ DOB:_____**

**Mother's Name: _____ SSN: _____ DOB:_____**

**Father's work phone: _____ Mother's work phone: _____**

**Primary Insurance: _____ ID#_____ Group#_____**

**Primary Insurance Phone #:_____**

**Secondary Insurance:_____ ID#_____ Group#_____**

**Secondary Insurance Phone #:_____**

**Self Pay: ___Yes ____ No**

**Presenting Concern:** Briefly state the problem for which you want help

_____

_____

**Brief History of Presenting Concern** (How long have you had this concern?)

_____

_____

**Current Medical Problems**

_____

**Medications, Drugs, Vitamins, Supplements, & Holistic Medicines you currently take, and reason for taking**

_____

**Have you ever experienced an addiction or dependence of a substance? Yes _____ No ____**

**If yes, which substance? _____**

**Have your close relatives (parents, grandparents, uncles, aunts, siblings) ever experienced an addiction or dependence of a substance? Yes _____ No ____. If yes, what relatives? _____**

**Have you ever experienced episodes of epilepsy or seizure?_____**

**Have you ever seen a counselor, psychologist, or psychiatrist before? _____**

**If yes, when and for what reasons? _____**

_____

**Did you find it helpful? Why or why not? _____**

_____

**Have you, in the past year, ever considered suicide? _____**

**Have you ever attempted suicide? _____**

**Do you have a spiritual/religious affiliation? If yes, please describe:_____**

_____

***Legal History***

**Presently, are you involved in any legal problems? _____ Have you had legal problems in the past? _____**

**If yes to either, please explain _____**

_____

**Name some of the top 5-10 things you love and/or enjoy doing**

**1. _____**

**2. _____**

**3. _____**

**4. _____**

**5. _____**

**6. _____**

**7. _____**

**8. _____**

**9. _____**

**10. _____**

**Transmission of Privileged Client Information**

It is my policy not to release financial or personal information by answering machine, home, work, or cell phone unless specifically instructed by you, the client. In order to leave specific information, I require permission from you. Indicate below how I may release sensitive information about you. You may change this at any time by signing a new release of Privileged Client Information Form.

Home Phone ____ Yes ____ No  Answering Machine ____ Yes ____ No  Email ____ Yes ____ No

Work Phone ____ Yes ____ No  Voice Mail ____ Yes ____ No  Email Address: _____

Cell Phone ____ Yes ____ No  Fax Records ____ Yes ____ No  _____

**Release of Privileged Information**

Information can only be released to the client, their guardian, the holder of their power of attorney or those specifically authorized by the client. Please list the names of those authorized to receive privileged information about you.

_____ _____ _____

Print Client's Name:_____

Client's or Guardian Signature: _____ Date: _____

**I hereby state that all information on this form is true to the best of my knowledge.**

_____ _____

**Client Signature** **Date**

**I authorize my credit card to be charged 50% or 100% of my therapist's fee for sessions that are missed per the policy outlined in the Office Policies.**

_____ _____

**Client's or Guardian Signature** **Date**

**Credit Card Information:**

Your completion of this authorization form helps us to protect you from credit card fraud. All information entered on this form will be kept strictly confidential.

Name on Card:_____

Billing Address: _____

Card Type: ___Visa ___ Mastercard___American Express

Card #:_____ Expiration Date: _____ CVC#:_____

*I understand the policy regarding paying for counseling services and/or missed appointments as described above.*
*I agree to be bound by the policies, terms and conditions for counseling services.*

Cardholder Signature (Required): _____

*Attach a photocopy of the front and back of the signed credit card.*

4Directions Counseling
Mind. Body. Heart. Spirit.

## Acknowledgement of Receipt of the OFFICE POLICIES and Review of the HIPAA Notice of Privacy Practices

**By signing this form, I acknowledge that:**

- **I have received a copy of OFFICE POLICIES;**
- **I have seen the HIPAA notice of privacy practices;**
- **I have been offered an opportunity to review both of these documents and ask all of the questions I had about these policies and procedures; and,**
- **I am in agreement with the stated terms and conditions.**

_____ _____

Client- Signature Date

## Social Media Policy Acknowledgment

By signing below, I acknowledge that I have read, understood, and retained a copy of the Social Media Policy which outlines office policies related to use of Social Media. I understand that if I have questions about this policy, I can bring them up when I meet with my therapist. I understand there may be times when this policy may need to be updated. I understand I will be notified in writing of any policy changes and will be provided with a copy of the updated policy.

_____

Client- Print Name

_____ _____

Client- Signature Date

_____ _____

Witness Signature Date