Diane Sinclair-Smith
Licensed Clinical Marriage & Family Therapist

CLIENT INTAKE

PERSONAL:

Today's Date:_____

Client name:_____ Date of Birth:_____

Address:_____ Age : _____

City: _____ State:_____ Zip:_____

Home phone: _____ Message ok? yes __ no __

Work phone: _____ Message ok? yes __ no __

Cell phone: _____ Text ok? yes __ no __

E-mail address: _____ Permission to use: _____(initial)

Referred by: _____

EMPLOYMENT/EDUCATION:

Highest level of education _____ Occupation/Title _____

Current employer/business/school _____

EMERGENCY CONTACT:

Name: _____ Phone:_____

Relationship to client: _____

FAMILY HISTORY:

Marital status: single ___ married ___ divorced ___ widowed ___ other _____ (specify)

If married, name of spouse _____ Age _____

Children(s) name(s)/Age(s):_____

_____

Who lives with you at this time? _____

Father: living? ____ deceased? _____ his age _____ your age when he passed? _____

Mother: living? ____ deceased? _____ her age _____ your age when she passed? _____

Please list your siblings with current ages:

_____

_____

Any family history of Psychological/behavioral problems?: _____

Has anyone close to you ever committed suicide? _____ whom? _____

Have you ever attempted suicide? _____ when? _____

Have you ever been abused? ____ physically? _____ sexually? _____ emotionally? _____

Who provides you with emotional support at this time? _____

MEDICAL INFORMATION:

Primary Care Physician: _____ Phone: _____

Practice address: _____

List all **significant** illnesses/physical problems/medical procedures/allergies you have had: _____

_____

_____

List current medications and supplements (please include name, purpose, & dosage of each med.):

_____

_____

_____

List any counseling/psychiatric treatment you have ever received or are currently receiving (incl. name of provider(s)):

_____

_____

_____

ABOUT THERAPY

Why are you seeking therapy at this time?_____

How long has this been a problem for you? _____

Please check all applicable problem areas:

	Personal Relationship		Legal/Police		Addiction
	Marital		Sexual		Alcohol
	Family		Emotional		Drugs
	Childrearing		Incest		Abuse
	Financial		Other		

What are your goals for therapy? _____

Do you believe in or belong to a certain type of religion or belief system? Yes __ No __

Would you like to include spirituality in our counseling sessions? Yes ☐ No ☐ Not Sure ☐

Do you use any of the following substances?	Yes	No	how much
Caffeine	___	___	_____
Alcohol	___	___	_____
Nicotine	___	___	_____
Drugs (recreational/pharmaceutical)	___	___	_____

INSURANCE

Do you plan to use health insurance? Yes ☐ No ☐

If yes, please call your insurance company in advance to confirm coverage & determine if you need a pre-authorization number for behavioral health coverage, your co-pay amount, & number of available sessions.

Insured's name (if different than client) _____ Date of birth _____

Address _____

Relationship to client _____

Employer _____

Name of Insurance Co./Managed Care Organization: _____

ID # _____ Group # _____

Please bring a copy of your insurance card (front & back) or the Insurance card with you to your first appointment.

.

RELEASE OF INFORMATION: (please initial and date applicable statements below)

Insurance Clients:

	Initial	Date
I authorize the release of all records generated as the result of my contact with this office. These records may be released to any organization, insurance or managed care company that may require records in order to process any claim related to these services .	_____	_____
I assign payment of benefits for outpatient services to this office. I understand that I am responsible for satisfying any pre-certification requirements of my insurance. I further understand that I have complete responsibility for any penalties, denial, disputes of non-payment for services by my insurance/managed care company.	_____	_____

.

_____

I have reviewed the above information & to the best of my knowledge it is correct & complete. _____ _____

_____

(signature of client)