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Client Intake Form

Date: _____ How did you find out about Stephanie/The VIC center? _____

Name _____ DOB _____ GENDER _____

Address _____

City _____ State _____ Zip _____ Phone (cell/home/work) _____

Email Address _____

Preferred Mode of communication ☐ Email ☐ Phone
** Email and texts correspondence is not guaranteed to be a confidential mode of communication*

Employer Name _____ Occupation _____

1. **What is your ethnicity/race? _____**
2. **Who do you live with? _____**
3. **Who is your support system? _____**
4. **Emergency Contact? _____ Phone _____**
5. **Do you have siblings? ☐ Yes ☐ No**

   How many sisters? _____ List ages _____

   How many brothers? _____ List ages _____
6. **Do you have children? ☐ Yes ☐ No**

   How many daughters? _____ List ages _____

   How many sons? _____ List ages _____
7. **Are you currently in a relationship? ☐ Yes ☐ No**

   Status: ☐ Married/Partner ☐ Living together ☐ Dating ☐ Separated ☐ Poly

   How long in the current/primary relationship*?*_____

   Number of Divorces*:* _____

8. **Are you currently taking any psychiatric medication(s)?** ☐ **Yes** ☐ **No**

If yes, please list: _____

Prescriber: _____ **Current Provider?** ☐ **Yes** ☐ **No**

Will you sign a Release of Information for the above provider? ☐ **Yes** ☐ **No**

9. **Have you ever been treated at a psychiatric hospital?** ☐ **Yes** ☐ **No**

If yes, dates and facility: _____

10. **Have you ever had counseling/therapy before?** ☐ **Yes** ☐ **No**
If Yes: When and how long? _____

11. **Are you currently seeing another therapist?** ☐ **Yes** ☐ **No Purpose:** _____

Will you sign a Release of Information for the above provider? ☐ **Yes** ☐ **No**

12. **Are you currently having any thoughts of hurting yourself or others?** ☐ **Yes** ☐ **No**

If yes please describe: _____

_____

13. **Do you drink alcohol?** ☐ **Yes** ☐ **No**

How many times per week? _____ **Drinks per sitting:** _____

14. **Do you use any other substance?**

Substance: _____ **Per week?** _____ **Amount:** _____

Substance: _____ **Per week?** _____ **Amount:** _____

Substance: _____ **Per week?** _____ **Amount:** _____

15. **Do you need help decreasing your use?** _____

16. **How would you rate your overall physical health?**

☐**Excellent** ☐ **Very good** ☐ **Good** ☐**Not very good** ☐**Poor**

Please list any medical issues you have: _____

_____

Current Treatment Provider: _____

Will you sign a Release of Information for the above provider? ☐ **Yes** ☐ **No**

15. **What significant life changes or stressful events may impact your reason for coming in today?**

If yes, please describe: _____

_____

_____

16. **Is there anything else you would like to share that you think would be helpful for me to know?**

_____

_____