Therapy Intake Form Template

Patient Information

First Name	Last Name	Preferred Name	Patient Identifier (If known)

Gender	Preferred Pronouns	Date of Birth	Marital Status

Address	City	State	Zip Code

Email	Preferred Phone Number

Emergency Contact

Full Name	Relationship	Contact Number
Full Name	Relationship	Contact Number

Health and Medical Information

Primary Care Physician	Address	Contact Number
Psychiatrist	Address	Contact Number

Please list any medical conditions

Please list any current medication

Insurance Information (If Applicable)

Insurance Carrier	Insurance Plan	Contact Number
Policy Number	Group Number	Social Security Number

Employment Status

Employed Self Employed Unemployed Other _____

Occupation	Industry	Company Name

Company Address	City	State	Zip Code

Availability

Please describe your availability throughout the week

Patient Information

First Name	Last Name	Date of Birth	Gender

Personal and Family

What is your ethnicity?

How many people are in your household?

What is your income level?

What is the highest education level you've completed?

Have you ever been hospitalized for a psychiatric illness?	☐ Yes	☐ No
Does any family members have a history of mental illness?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Has any family members ever attempted or committed suicide?	☐ Yes	☐ No
Do you have problems with substance abuse?	☐ Yes	☐ No
Does any family members have problems with substance abuse?	☐ Yes	☐ No
Have you ever been arrested? If yes, please explain:	☐ Yes	☐ No

How are you doing at your job?

☐ I. Not working ☐ II. Cannot Function ☐ III. Serious Problem ☐ IV. Mild Problem ☐ V. No Problem

How are you doing at in your marital or with your significant other?

☐ I. Not working ☐ II. Cannot Function ☐ III. Serious Problem ☐ IV. Mild Problem ☐ V. No Problem

How are you doing in relationships with family member?

☐ I. Not working ☐ II. Cannot Function ☐ III. Serious Problem ☐ IV. Mild Problem ☐ V. No Problem

How are you doing in relationships with non-family member?

☐ I. Not working ☐ II. Cannot Function ☐ III. Serious Problem ☐ IV. Mild Problem ☐ V. No Problem

How is your overall happiness and well-being?

☐ I. Not working ☐ II. Cannot Function ☐ III. Serious Problem ☐ IV. Mild Problem ☐ V. No Problem

All the answers given to the above questions are answered accurately to the best of my knowledge. I understand that any inaccurate information can be dangerous to my (or patient's) health.

Parent or Guardian Name (If Applicable)	Relationship to Patient (If Applicable)
Signature of Patient, Parent or Guardian	Date