CLIENT INTAKE FORM

DUSTIN SMITH
2565 THOMPSON BRIDGE ROAD
GAINESVILLE, GEORGIA 30501

DATE: _____

NAME: _____
FIRST MIDDLE LAST

PREFERRED NAME: _____

DATE OF BIRTH: _____

HOME STREET ADDRESS: _____

CITY:_____ STATE:_____ ZIP: _____

HOME PHONE:_____

WORK PHONE:_____

CELL PHONE: _____

EMAIL: _____

MAY I CONTACT YOU AT THE ABOVE CONTACT INFORMATION IN REGARDS TO APPOINTMENTS? ☐ YES ☐NO

MAY I TEXT YOU IN REGARDS TO APPOINTMENTS? ☐ YES ☐ NO

EMERGENCY CONTACT NAME: _____

EMERGENCY CONTACT NUMBER: _____

RELATION: _____

I WILL ONLY CONTACT THIS PERSON IF I BELIEVE IT IS A LIFE OR DEATH EMERGENCY.

REFERRED BY:

☐ MEDICAL PROVIDER
☐ WEBSITE
☐ FRIEND/FAMILY
☐ OTHER _____

HAVE YOU PREVIOUSLY RECEIVED ANY TYPE OF MENTAL HEALTH SERVICES?

☐ YES

☐ NO

IF SO, WHICH OF THE FOLLOWING?

☐ PSYCHOTHERAPY

☐ MEDICATION

☐ OUTPATIENT HOSPITALIZATIONS

☐ INPATIENT HOSPITALIZATIONS

DATES OF LAST MENTAL HEALTH SERVICES AND REASON FOR DISCONTINUATION

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WHAT BRINGS YOU IN TODAY?

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DO YOU HAVE ANY GOALS FOR THERAPY?

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