Urban Healing Counseling, PLLC

Client Intake Form

Date: ____

Client's Name (First Middle Last):____

SS#:____

Age:____

DOB (mm/dd/yyyy):____

Home address (including city, state zip code):

____

May we send mail to this address? ☐ Yes ☐ No

Gender: ☐ Male ☐ Female ☐ Other:____

Racial/Ethnic Identity: ☐ African-American ☐ Asian-American ☐ White ☐ Hispanic

☐ Native-American ☐ Other: ____

Primary language: ☐ English ☐ Spanish ☐ Other: ____

Marital Status: ☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
☐ In a committed relationship ☐ Other: ____

Sexual Orientation: ☐ Heterosexual ☐ Bisexual ☐ Homosexual ☐ Other: ______________________

Religious/Spiritual Traditions or Identity (if applicable): ____

Do you have children? ☐ Yes ☐ No If so, how many?____

Does your children live with you? ☐ Yes ☐ No
People that reside with you:

Name	Relationship to self	Age

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Additional client's contact information:

Phone Numbers:

Cell: ______________________ Work: _____________________Home:__________________

Which number do you wish to be reached at: ☐ Cell Phone ☐ Work Phone ☐ Home Phone

May I leave a message? ☐ Yes ☐ No

E-mail:____

May I email you? ☐ Yes ☐ No (email correspondence will be only used for scheduling and billing purposes (e.g. to schedule, to cancel or to change appointment, remind you about payment).

Please note that email correspondence is not considered to be a confidential medium of communication

Are you employed? ☐ Yes ☐ No

Client's Occupation: ____

☐ Full-time ☐ Part-time ☐ Self employed ☐ Unemployed

Are you military? ☐ Yes ☐ No

Have you served in the past? ☐ Yes ☐ No

Are you in school? ☐ Yes ☐ No

Name of School: ____

☐ Full-time ☐ Part-time

Insurance information (Please give your insurance card therapist)

Are you using insurance? ☐ Yes ☐ No *Complete section only if you are using insurance*

List mental health/ behavioral health insurance company: _____________________________

Subscriber's name: ____

Subscriber's relationship to client name: ☐ Spouse ☐ Parent ☐ Other :____________

Subscriber's Birth date: ____

Subscriber's SS#: ____

Address (if different from client's):

____

____

Home phone number (if different from clients): ____

Subscriber Employer: ____

Emergency Contact

If there is an emergency during our work together, or I become concerned about your personal safety, I will contact someone close to you—perhaps a relative, spouse, or close friend. Please write down the name and information of your chosen contact person in the blanks provided:

Emergency Contact Name: ____

Relationship to patient: ____

Cell Phone________________ Work Phone___________________ Home Phone____________

E-mail____

Secondary Emergency Contact Information - if you have

Emergency Contact Name: ____

Relationship to patient: ____

Cell Phone________________ Work Phone___________________ Home Phone____________

E-mail____

Medical Information

Name and phone number of current physician:____

Are you currently taking any prescription medication (including psychiatric medication) or over-the-counter vitamins, supplements, herbs, and others: ☐ Yes ☐ No

If yes, please list name of medication, dosage and frequency

____

____

Do you have any current medical problems ☐ Yes ☐ If yes please list

____

Do you have history of medical problems ☐ Yes ☐ If yes, please list

____

Do you have drug allergies or any other allergies: ☐ Yes ☐ No If yes, please list

____

Mental Health Information

Have you received any type of mental health services (psychotherapy, psychiatric services, etc.) in the

past? ☐Yes ☐ No

If yes when (month/ year) and previous practitioner/therapist?

____

For what purpose? ____

Have you ever been diagnosed with a psychiatric condition? ☐ Yes ☐ No If yes, please list what was the diagnosis

____

Have you ever been prescribed psychiatric medication? ☐ Yes ☐ No If yes, please list what was the medications

____

Have any immediate family members that are deceased? ☐ Yes ☐ No If so, who and the what month/ year did they pass

____

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Are any of the following conditions a problem for you at this time? (Circle all that apply)

Anxiety	Self esteem	Loss of Meaning in life
Grief	Stress	Mood swings
Sadness	Conflicts at work/school	Motivation
Irrational fears	Chronic fear	Religious doubts
Nervousness	Guilt feelings	Sleep issues
Loneliness	Panic attacks	Anger, Aggression
Violence	Loss of Hope	Attention issue
Sexual concerns	Loss of work/job	Delusions (False ideas)
Low energy	Hallucinations	Other: ________________

Issues with: ☐ Drugs ☐ Alcohol ☐ Gambling ☐ Sex ☐ Other: _____________________

Relationship problems: ☐ Yes ☐ No if yes with whom: ☐ Spouse ☐ Child
☐ Parents ☐ Other: ____

Any family members with mental health issues: ☐ Yes ☐ No

If so whom: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐Aunt/ Uncle ☐ Grandparent

If so what issues? Please list: ____

Legal Issues, etc.

Current legal issues: ☐ Yes ☐ No Current probation or parole ☐ Yes ☐ No
If yes please describe:____

History of legal issues: ☐ Yes ☐ No
If yes, please describe:____

Child protective or Adult protective services involved in home: ☐ Yes ☐ No
If yes, please describe nature of involvement:____

Additional Information

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Anything else you wish to share with therapist such as (e.g. religious beliefs, concerns about therapy etc)

☐ Yes ☐ No If yes, please describe

____

____

Reason you/client is seeking counseling?

____

____

What specific behaviors, actions, feelings, or habits would the client like to change about themselves?

____

____

What are some of the client's special talents or skills that they feel proud of?

____

____

____
PRINT Client or Legally Responsible Person

_________________________________ ____________________
Signature Client or Legally Responsible Person Date

_________________________________ ____________________
Therapist Signature Date

Referred by (Name): ____

May I let this person know that you have come to see me? ☐ Yes ☐ No