



Date: _____

CLIENT INTAKE INFORMATION

Name: _____ DOB: _____

Birth Assigned Gender: _____ Current Gender Identity: _____

Current relationship status: _____

Children: Y N If yes, how many: _____

Address: _____

City/St/Zip: _____

Home/Cell #: _____ Work #: _____

Employer: _____

Occupation: _____ How Long? _____

Please acknowledge whether you utilize the following types of care and, if so, list the names of providers with whom you currently work:

Physician (MD or DO) Y N _____

Homeopath/Naturopath Y N _____

Chiropractor Y N _____

Acupuncturist Y N _____

Other Healing Arts Y N _____

Current/ongoing Medical Conditions: _____

What brings you here today? _____

Name _____ Date _____

Current Medications/Herbs/Supplements:

Rx	Reason for taking	Dosage	Date prescribed
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Previous Counseling and/or Mental Health Hospitalizations:

Dates/Location	Reason	Outcome – (i.e. issue resolved?)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Emergency Contact Information

Name: _____ Phone: _____
Relationship: _____
