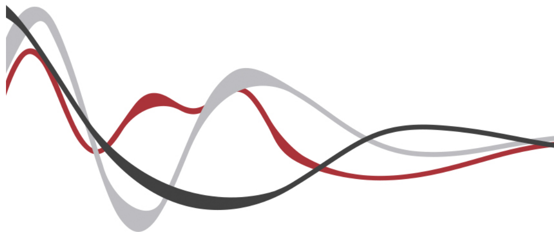

EVANFREEDMAN PhD, ABPP
Licensed Psychologist #2306

CLIENT INTAKE FORM
Please complete both sides of form.

Today's Date: ____________________
Name:____ Social Security#: ___________________
Address: ____ Email:_____________________________
Home Phone: ________________________ ☐ day ☐ evening OK to leave msg? YES NO
Work Phone: _________________________ ☐ day ☐ evening OK to leave msg? YES NO
Cell Phone: __________________________ ☐ day ☐ evening OK to leave msg? YES NO
Date of Birth: ________________________ Gender: ___________________

Referred by: _________________________ Primary Care Physician: ________________________

PRIMARY INSURANCE INFORMATION (on card)
Insurance Company: ____________________________________ Phone#: ______________________
Insurance Company Address: ____
Subscriber's Name: _________________________ Relationship to you: _______________________
ID#: _______________________________________ Group/Plan #: ______________________________

SECONDARY INSURANCE INFORMATION (on card)
Insurance Company: ____________________________________ Phone#: ______________________
Insurance Company Address: ____
Subscriber's Name: _________________________ Relationship to you: _______________________
ID#: _______________________________________ Group/Plan #: ______________________________

PERSONAL INFORMATION
Where were you born/raised? ____
Religion (optional): ______________________ Important in up-bringing? YES NO Still? YES NO

Educational Level (Circle): 8 9 10 11 12 13 14 15 16 17 18 19+
Occupation: _________________________ Employer: ___________________ For how long? ______

Emergency Contact: ________________________________ Relation: _________________
Phone #(s): (1) ________________________ (2) ________________________

COUNSELOR'S NOTES (for office use only)

Date	dx code	dx	Counselor Signature

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MEDICAL HISTORY

(All current medications-including herbal and over-the-counter)

Medication: ______________________________ Dosage: _______________ Date Started: _________
Medication: ______________________________ Dosage: _______________ Date Started: _________
Medication: ______________________________ Dosage: _______________ Date Started: _________

Significant Medical Problems-
Past: ____
Present: ____
Allergies: ____
Alcohol Use-
Past: ____
Present: ____
Drug Use-
Past: ____
Present: ____
Tobacco Use-
Past: ____
Present: ____
Caffeine Use-
Past: ____
Present: ____

Have you had previous counseling? ☐ Yes ☐ No
If yes, with whom? ____ When? ___________________
Would it help to contact your previous counselor (s)? ☐ Yes ☐ No

FAMILY SITUATION

Relationship/Marital Status: ☐ Single ☐ Involved ☐ Engaged ☐ Cohabitating
☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Marriages, Significant relationships, and children:

Partner/Spouse	From (Year)	To (Year)	Names & ages of children from relationship	Where/with whom do they live?

GOALS FOR THERAPY

What would you like to see happen as a result of your work here?

____
____
____

12/15/14

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