1095 Pingree Road, Suite 202
Crystal Lake, IL 60014

Client Intake Form

(confidential)

Client Name: _____ Date: _____

Parent's Name (if child receiving counseling): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Home: _____ Cell: _____ Work: _____

Age: _____ Birth Date: _____

Education (grade completed/college): _____

Children: (gender & age): _____

Siblings in the home: _____

Referred by: _____

Person to alert in the event of an emergency:

Name: _____

Relationship to client: _____ Phone: _____

Primary Care Doctor: _____

Address: _____ Phone: _____

1095 Pingree Road, Suite 202
Crystal Lake, IL 60014

Psychiatrist: _____

Medications:

Insurance Information:

Policy Holder (Member) Name: _____

Relation to Cient: _____

Policy Holder (Member D.O.B.): _____

Insurance Company: _____

Insurance Phone Number: _____

Member ID Number: _____

Group Plan Number: _____

Please describe any significant current or past medical problems:

Have you had previous psychiatric care of counseling? YES ☐ NO ☐

If yes, please give the name of the clinician(s), the months you saw them (e.g., Nov 06 – Feb 07), and the nature of the difficulty at the time:

1095 Pingree Road, Suite 202
Crystal Lake, IL 60014

Have you ever been hospitalized for a psychological or psychiatric difficulty? YES ☐ NO ☐

If yes, please give the dates and the nature of the difficulty at the time:

In your own words, what is the nature of the concern that you wish to address in therapy? Feel free to describe this in as much or as little detail as you wish. Use additional paper if you like.

Therapy can be powerful force for change. For it to be most effective it helps to have a clear and specific goal. You may find it difficult to express your hopes for therapy in the form of a goal, but please make at least an initial effort. You can discuss this further with your therapist. Feel free to list more than one goal if you wish.

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature Date