PSYCHOTHERAPY INTAKE

Client Information:
Full name: ______________________________Preferred name: ________________
Social Security Number: __________________ Driver's License: _______________
Date of Birth: ______________ Age: ________
Address: ____
City/State/Zip: ____
Home Phone: ____________ Cell Phone: ____________ Work Phone: ___________
Which phones are okay to leave a message? _____Home _____Cell _____Work
Email Address: ____
Do you have any objections to being contacted by phone, mail or email? *Yes No*
How would you like to be contacted? ______________________________________
Referred by: _________________________Permission to thank referral? *Yes No*
Physician: ______________________________ Phone: _______________________
Psychiatrist: ____________________________ Phone: _______________________
Current Medications: ____
Emergency Contact Name: _________________ Relationship to Client: _________
Home Phone: ____________ Cell Phone: ____________ Work Phone: ___________

Parents/Guardians if Client a Minor or Partner/Family Member if CT/FT:
Full name: ______________________________Preferred name: ________________
Social Security Number: __________________ Driver's License: _______________
Date of Birth: ______________ Age: ________
Address: ____
City/State/Zip: ____
Home Phone: ____________ Cell Phone: ____________ Work Phone: ___________
Which phones are okay to leave a message? _____Home _____Cell _____Work
Email Address: ____
Do you have any objections to being contacted by phone, mail or email? *Yes No*
How would you like to be contacted? ______________________________________

I certify that the above information is correct.

____ _______________
Client Signature(s) Date

____ _______________
Parent/Guardian Signature(s) Date

Daring Discoveries, PLLC | Lee Ann Hilbrich, MA, LMFT, LPC, CDWF | 281.816.6854
2951 Marina Bay Dr. Ste. 130-643 League City, TX 77573 | www.daringdiscoveries.com