

# PSYCHOTHERAPY INTAKE FORM

## Client Information:

Full Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

## Emergency Contact Information:

Full Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

## Insurance Information (if applicable):

Insurance Provider: \_\_\_\_\_  
Policy Number: \_\_\_\_\_  
Group Number: \_\_\_\_\_

## Presenting Problem / Reason for Seeking Therapy:

## History of Present Problem:

## Mental Health History:

Have you previously received psychotherapy or counseling?  Yes  No

If yes, please describe briefly:

## Medical History:

Are you currently under the care of a physician or psychiatrist?  Yes  No

If yes, please specify reason and medications currently prescribed:

I voluntarily consent to participate in psychotherapy and understand that therapy involves a collaborative process which may include discussing personal issues and emotions. I understand that the therapist will maintain confidentiality except as required by law or ethical guidelines, including but not limited to, risk of harm to self or others, abuse, or court orders.

**Confidentiality and Limits:**

I understand that information shared in therapy is confidential and will not be disclosed without my consent, except where disclosure is required or permitted by law, including but not limited to child or elder abuse, imminent risk of harm, or court orders. I have been informed of these limits and my rights regarding privacy.

**Client Rights and Responsibilities:**

I understand that I have the right to ask questions about my therapy, to discuss concerns about the treatment, and to end therapy at any time. I am responsible for attending scheduled sessions on time and for notifying my therapist in advance of cancellations. Fees and payment policies have been explained to me.

**CLIENT'S SIGNATURE**

**THERAPIST'S SIGNATURE**

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

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