horizontal line

**Client Intake Form Therapy**

* **Personal Information:**
  + **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
  + **Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
  + **Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
  + **Contact Information: \_\_\_\_\_\_\_\_\_\_**
* **Health History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Current Concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Therapy Goals:**
* **Emergency Contact Information:**
  + **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
  + **Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
  + **Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Consent to Therapy: ☐ Yes ☐ No**
* **Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**