

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**