



INTAKE INFORMATION

Date: _____

Patient Information:

Name: _____ Age: ____ DOB: _____

Ethnicity: _____ Social Security Number: _____

Insurance Type/ Number: _____

Current Address: _____

City/State: _____ Zip Code: _____

Phones (home): _____ (cell): _____ (work): _____

Place/type of Employment: _____

Please check one: Married Divorced Single, never married

Is the client currently seeing any other counselors or mental health therapists: Yes No

If yes, please list name of counselor and date of last appointment: _____

Person responsible for payment:

Name: _____ Age: _____ DOB: _____ Ethnicity: _____

Insurance Type/ Number: _____

Current Address: Same as above

City/State: _____ Zip Code: _____

Phones (home): _____ (cell): _____ (work): _____

E-mail Address: _____

Place/type of Employment: Same as above

Referral Source:

Name: _____

Address: _____ Phone: _____

Email (if available): _____

*Patient is responsible for payment (co-payment) upon receipt of services.



Intricate Minds, LLC
9160 Roe Street, Suite 5 Pensacola, FL 32514
PHONE: (850) 417-9231 FAX: (850) 792-6118

Family Information:

Mother's Name: N/A Client is not a minor _____
 DOB: _____ Age: _____ Ethnicity _____
 Current Address: _____
 Phone: _____ Email: _____

Father's Name: N/A Client is not a minor _____
 DOB: _____ Age: _____ Ethnicity _____
 Current Address: _____
 Phone: _____ Email: _____

Spouse's name: N/A Client is a minor _____
 DOB: _____ Age: _____ Ethnicity _____
 Current Address: _____
 Phone: _____ Email: _____

Current Caregivers

Same as above N/A Client is not a minor

Name: _____ Relationship: _____
 Phone: _____ Address: _____

Current Health History:

Does the client have any current or chronic health issues? Yes No If yes, please list:

Is client currently taking any medication? Yes No If yes, please list:

Type:	Start Date:	Dosage:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Medical History (Current or past):

	Client <input type="checkbox"/> Unknown	Mother <input type="checkbox"/> Unknown	Father <input type="checkbox"/> Unknown
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lung problems (asthma)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Miscarriages	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Learning problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nerve problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mental illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drinking problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Domestic violence(victim)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No



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Client's Primary Care Physician Name and Phone Number:

_____ Date of last Apt: _____

Any other Healthcare Provider(s) Name and Phone Number:

_____ Date of last Apt: _____

If the client is a minor, are his/her immunizations (shots) up to date N/A Yes No

Has the client ever been Hospitalized: Yes No

If yes, When? _____ Where? _____ Reason? _____
When? _____ Where? _____ Reason? _____

Does the Client have any Allergies? Yes No If yes, please list:

Allergy to: _____

Reactions: _____

Are you allergic to any medications? Yes No If yes, please list: _____

Employment/Education Information

Is client currently Employed: Yes No If yes, Name of employer: _____

Is client currently enrolled in school? Yes No If yes, please list: _____

Does the Client have any Children? Yes No If yes, please list:

Name	Date of Birth/Age:
_____	_____
_____	_____
_____	_____
_____	_____

Does the Client have any Siblings? Yes No If yes, please list:

Name	Date of Birth/Age:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____