Animas Family Therapy, LLC

Client Intake Form

Name: _____ Date of Birth: _____

Address: _____

_____

Phone: Cell: _____ Work or Home: _____

Email: _____

Employer: _____

Spouse/Significant Other: _____DOB: _____

Children's Names and Ages: _____

_____ _____

_____ _____

Physician's Name: _____ Phone #: _____

Current medications: _____

Any recent changes in eating or sleeping habits? _____

Suicidal Ideation? Yes _____ No _____ Suicidal Attempts? Yes _____ No _____

Alcohol or Drug Consumption: Alcohol? ___ How much? ___ How often? ___

Drugs? ___Type: _____ How much? ___ How often? ___

Any addictions in the family? ____ Explain: _____

_____

History of Abuse: Physical ____ Sexual _____ Verbal/Emotional _____

Please describe briefly: _____

Previous counseling experiences: _____

_____

Religion? Spiritual practice? _____ Activity level: _____

In the event of an emergency, please contact:

Name: _____ Relationship _____ Phone # _____

If client is a minor, Name of Parent/Legal Guardian: _____

Phone Number _____

Signature of Client: _____Date: _____

Signature of Client: _____Date: _____

Signature of Parent/Legal Guardian: _____Date: _____