

David Wilder, LICSW
Adult, Child, Adolescent and Family Psychotherapist/Counselor
CLIENT INTAKE – Adults

Today's Date: _____

Client's Name: _____

Address, City, Zip: _____

Home Telephone: _____ Cell Phone: _____

Date of Birth: _____ Type of Work/Employer: _____

Email: _____

Provide copy of insurance card or the following insurance information:

Insurance Co.: _____ Subscriber ID#: _____

Co Pay : _____ Coinsurance : _____ Effective date of Insurance: _____

(This information is not a guarantee of coverage, I will not know your exact benefits & coverage until I receive an explanation of benefits from your insurance company after first billing.)

Primary Care Physician

Name: _____ Phone: _____

Is there information that would be helpful for me to obtain from your PCP? Yes No

Medical/Psychological Information

Are you taking any medications? Yes No

If yes, please list the name of prescriber, medication and dosage:

Have you ever received counseling/psychotherapy services **in the past**? Yes No

If so, with whom and when? Diagnosis? _____

Why are you here today?:

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With whom do you presently live?

Name	Age	Relationship to You

Family History

Please note if any of these issues are present in your life or with your family (identify who has what):

ADD/ADHD _____

Allergies _____

Anxiety _____

Asthma _____

Autism _____

Bipolar Disorder _____

Criminal History _____

Depression _____

Divorce _____

Exposure to Domestic Violence _____

Head Injury _____

Physical abuse _____

Sexual Abuse _____

Sleep Disorder _____

Suicidal Thoughts _____

Substance Abuse _____

Victim of a crime _____

Other Health Concerns: _____