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(s or the following insurance information:

Insurance Co.: _____Subscriber ID#: _____

Supplemental or Additonal insurance: _____

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 seeking services today?:

_____

_____

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With whom do you presently live or have a significant relationship with?

Name	Age	Relationship to You	Live with

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_____

Guns in the home? _____

Other Health Concerns:_____