Societ

Client Intake Form

Date of Visit		Administrator Name	
First Time Visit	Y/N	Administrator ID No.	
Primary Care Physician Name			
Primary Care Physician Contact Number			
Mode of Admission (Please circle)		Walk-in	Referral
Referred By			

Client Information

Client Category	☐ Child ☐ Youth ☐ Family	☐ Adult ☐ Solo Parent ☐ Senior Citizen	
Full Name		Date of Birth	
Preferred Name		Social Security Number	
Legal Sex		Gender Identity	
Primary Address		Email	
Contact Number		Civil Status	

Occupation		Employment Status	
Do you have a guardian: Y/N			
Guardian Name		Guardian Contact Number	
Relationship		Email	

Family Composition

Please list all members of your current household, along with immediate family members.

Full Name	Date of Birth	Gender	Relationship to client

Concerns

What is the reason for your visit? What problems or issues are you currently experiencing?

What is the nature of the assistance you are seeking?	
Do you have any previous or ongoing physical or mental health conditions?	
Do you have any eating disorders?	
Do you have any sleeping disorders?	
How many cigarettes or tobacco products do you consume in a week?	
In what range do you use alcohol on weekly basis?	

Have you ever experienced any of the following?	
☐ Extreme anxiety ☐ Panic attacks ☐ Mood swings ☐ Depression ☐ Hallucinations ☐ Phobias	☐ Body image issues ☐ Repetitive thoughts ☐ Repetitive behaviours (handwashing etc.) ☐ Suicidal thoughts ☐ Homicidal thoughts
Has anyone in your family experienced any of the following?	
☐ Depression ☐ Bipolar disorder ☐ Panic attacks ☐ Schizophrenia ☐ Alcohol/substance abuse ☐ Chronic illness	☐ Hallucinations ☐ Eating disorders ☐ Learning disabilities ☐ Trauma history ☐ Suicide attempts
Social Worker Assessment	