**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  |
|  |

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