**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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