INTAKE FORM

Please fill out this form in as much detail as possible. We appreciate your taking time to provide us with this information which will help us understand your concerns and make an accurate diagnosis.

IDENTIFYING INFORMATION

Client's Name (*Last, First*) _____
Age_____ Date of Birth *(mm/dd/yyyy)* _____ Place of Birth (*City, State*)_____
Marital Status_____Education_____Occupation_____
Home Street Address_____
City _____State_____ Zip_____
Name of the person completing the form (*Last, First*) _____
Relationship to the client_____

CONTACT INFORMATION

Home Phone Number_____ Can we leave message: Yes ◉ No ○
Cell Phone Number_____ Can we leave message: Yes ◉ No ○
Work Phone Number_____ Can we leave message: Yes ◉ No ○
Preferred mode for contact: Phone ☑ Text ☑ Voice-mail ☐ Email ☑
Email Address _____
Emergency contact person's Name_____ Phone_____

FAMILY INFORMATION

Spouse / significant other's name (*Last, First*) _____
Child's name (*Last, First*) _____Age_____ Gender_____
Child's name (*Last, First*) _____Age_____ Gender_____
Child's name (*Last, First*) _____Age_____ Gender _____

BACKGROUND MEDICAL INFORMATION

Physician's Name (*Last, First*) _____
Psychologist's/Psychiatrist's Name (*Last, First*) _____
Any medical conditions: Yes ○ No ◉
Details_____
Any surgery, serious illnesses or accidents: Yes ○ No ◉
Details_____
Asthma / respiratory problems: Yes ○ No ◉
Details_____
History of abuse: Yes ○ No ◉
Details_____
History of Physical Trauma: Yes ○ No ◉
Details_____
History of Psychological Trauma: Yes ○ No ◉
Details_____
Family history of psychological disorders: Yes ○ No ◉
Details_____
Allergies: Environmental_____ Food_____ Other_____ None ____
Date of last evaluation for Vision_____ Outcome _____
Date of last evaluation for Hearing_____ Outcome_____
Date of last evaluation for Physical Therapy _____Outcome _____
Date of last evaluation for Occupational Therapy _____ Outcome_____
Date of last evaluation for Psychotherapy _____ Outcome_____
Date of last evaluation for Neurological Evaluation_____ Outcome_____

Online Therapy Services

Effective | Convenient | Secure

CURRENT MEDICAL INFORMATION

Symptoms:

Relationship/Family Stress ☐	Anger ☐	Substance Use ☐
Sad/Depressed Mood ☐	Anxiety ☐	Panic ☐
Work Stress ☐	Grief ☐	Insomnia ☐
Parenting Issues ☐	Obesity ☐	School problems ☐
Sexual Orientation concerns ☐	Suicidal ☐	Homicidal ☐
Abuse ☐	PTSD☐	Memory Loss ☐

Medication:

Name	Dosage	Since	Side Effects
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Reasons for seeking therapy: _____
_____
_____

CONSENT FOR TREATMENT

I voluntarily agree to and give consent for evaluation / treatment by Online Therapy Services for myself and/or my family members.

By signing this consent form, I am providing consent to the use of electronic and verbal signatures to establish my identity and sign electronic documents and forms associated with the provision of care by Online Therapy Services . I further agree that , for the purposes of authorizing and authenticating electronic health records , my electronic signature or verbal approval has the full force and effect of a signature affixed by hand to a paper document.

☐ By checking this box I accept the use of electronic and verbal signatures as a valid form of my written signature for documentation associated with my care.

Patient/Parent/Guardian Signature (Please type full name)_____
Printed Name: _____
Date:_____