

Client Confidential Intake Information

545 N Mountain Ave., Suite 206. Upland, Ca. 91786

Name: _____ Date _____

Phone: (Work) _____ (Home) _____

Cell Phone: _____ E-Mail: _____

Address: _____

City: _____ State: _____ Zip Code: _____

May I have permission to mail to this address? Yes _____ No _____

Sex: Male _____ Female _____ Date of Birth: _____

Others living at home _____ Occupation: _____

Employer _____ Work Address _____

How long have you worked there? _____

How long have you worked in this occupation? _____

Education: (List highest level of education attained) _____

Primary Physician: _____ Phone: _____

List any significant health problems: _____

List any medications you are taking and the dosage:

Prior Experience in Counseling? Yes _____ No _____

If yes, when and with whom? _____

Give a brief description of treatment:

Please describe your current and/or past recreational drug and alcohol use (including prescription drugs).

How were you referred to our office? _____

Financially Responsible Person's Information:

Name: _____ Relationship to Client: _____

Phone (if different from above): _____

Address (If different from above): _____

Insurance Carrier (if applicable): _____

Social Security Number of Insured: _____

Group Number: _____ Member Number: _____

Insurance Phone Number: _____

Consent for Treatment:

If client is a minor, please sign consent for treatment:

Client name (minor) _____

Parent or guardian name (print) _____

Parent or guardian signature _____