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Intake Form

Date: _____

DOB: _____

DOB: _____

Client Name: _____

Client Name: _____

Marital Status: _____

Others in household/relationship: _____

Presenting Problem (reason for treatment, symptoms, onset, duration)

Related History (same/similar problem, recent life changes, etc.)

Additional Stressors

Desired outcome for treatment

Previous counseling/treatment (incl. Substance abuse treatment) and outcome

Strengths

Support system

Current medical status, incl. Mental health diagnoses/medical treatment
