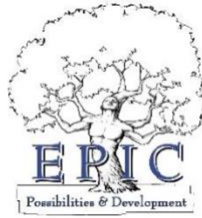

Intake Screening Form

Name: ________________________________ Date: ________________________

Email: _____________________________ Phone: ______________ DOB: ______________

Insurance Company: ____

Member #: __________________________________ Group #:__________________________

What brings you in for therapy at this time? ____
____
____
____

What are your goals for therapy? ____
____
____
____

Is there a specific type of therapy that you are looking for?

____
____
____
____

Have you been in therapy before? ____

If so, when? ____

What medications are you on? ____
____

How did you hear about therapy with us? ____

In the last two weeks have you considered suicide or homicide? _________________________________

If yes, do you have a plan?____

Have you recently received inpatient treatment for mental health? ______________________________

If so, where? ____