

Interviewer Name & Designation: _____ Date of Intake: _____

Intake Form

Name (client):	Date of Birth:	Age:
Address:		
Phone:		
Email:	Occupation:	
Race/Ethnicity (optional):	Permission to leave VM?	send text (appointments)?
send emails?		
Relationship status (check one):		
Married/partnership____ Separated____ Divorced____ # ____ Widowed____ Never Married____		
Name of Spouse/Partner (for couples):		
Date of Birth:	Age:	
Address:	Phone:	
Email:	Occupation:	
Race/Ethnicity (optional):		
Permission to leave VM____ send text (appointments)____ send email____		
Emergency Contact Name:		
Relationship:	Phone:	

Children: Yes ___ No ___ (if "Yes," list children's information below)

Name	Date of Birth	Gender	Custody/Adult

List Physicians or mental health providers that you would like us to be in contact with (ROI will need to be completed):

Name	Address	Services provided	Phone