Amber Creek Family Counseling & Psychiatry, Inc.

9035 South 1300 East Suite 120 Sandy, UT 84094

www.AmberCreekCounseling.com

INTAKE FORM

**Please fill out this form and bring it to your first appointment*

Client Information:

Client Name:_____ Today's Date: _____
(Last) (First) (Middle Initial)

Birthdate:_____ Age:_____ Gender: ☐ Male ☐ Female Marital Status: M S D Sep

Client Name:_____ Today's Date: _____
(Last) (First) (Middle Initial)

Birthdate:_____ Age:_____ Gender: ☐ Male ☐ Female Marital Status: M S D Sep

Address:_____City:_____State:_____Zip:_____

Home Phone: (_____)_____ May we leave a message? ☐ Yes ☐ No
Work Phone: (_____)_____ May we leave a message? ☐ Yes ☐ No
Cell Phone: (_____)_____ May we leave a message? ☐ Yes ☐ No
Email Address:_____ May we email you? ☐ Yes ☐ No

Responsible Party Info (if applicable):

Name:_____ Relationship to Client:_____DOB:_____

Address:_____City:_____State:_____Zip:_____

Home Phone: (_____)_____ May we leave a message? ☐ Yes ☐ No
Work Phone: (_____)_____ May we leave a message? ☐ Yes ☐ No
Cell Phone: (_____)_____ May we leave a message? ☐ Yes ☐ No
Email Address:_____ May we email you? ☐ Yes ☐ No

Referred by:_____ How did you hear about us?_____

What kind of services are you seeking? ☐ Counseling/Therapy Services
☐ Psychiatric Consultation
☐ Both

If you are seeking counseling, what type of services are you seeking: ☐ Individual ☐ Couple ☐ Family

Reason for seeking appointment: _____
What do you hope to gain from your visit?_____
_____

Have you received therapy/counseling before? If yes, with whom? _____Dates:_____
Have you visited a psychiatrist before? If yes, with whom? _____Dates:_____

What psychiatric medications are you currently taking (include dosages)? _____
What psychiatric medications have you taken in the past? _____
Have you had any adverse reactions to psychiatric medications in the past? _____
Do you have any allergies to medications? _____
Do you have any medical conditions? _____
Have you ever had a mental health diagnosis? _____

Who may we contact in case of emergency?
Name: _____ Relationship:_____ Phone: _____

Client Signature: _____ **Date**:_____

Client Signature: _____ **Date**:_____

Guardian Signature (if applicable): _____ **Date**:_____