

INTAKE FORM

CLIENT NAME:

(Last, First, M.I.)

NAME OF PARENT OR GUARDIAN (if under 18yo):

(Last, First, M.I.)

DATE OF BIRTH: _____ **AGE:** _____ **GENDER:** _____

MARITAL STATUS (check one):

Never married Domestic partnership Married Separated Divorced Widowed

Please list any children and their ages:

ADDRESS:

(street and number)

(city)

HOME PHONE: _____ **MAY WE LEAVE A MESSAGE? Y / N**

CELL PHONE: _____ **MAY WE LEAVE A MESSAGE? Y / N**

EMAIL: _____ **MAY WE EMAIL YOU? Y / N**

*Please note: Email correspondence is not considered to be a confidential medium of communication

REFERRED BY (if any): _____

Nicole Valdes PH.D.
& ASSOCIATES P.A.

Please describe any previous mental health services you've received:

Please list current medications:

Please list any current health problems:

Are you currently experiencing overwhelming sadness, grief, or depression? Y / N
If yes, please describe:

Are you currently experiencing anxiety, panic attacks, or phobias? Y / N
If yes, please describe:

What significant life changes or stressful events have you experienced lately?

What would you like to accomplish in your time in therapy?
