

**LIFE SKILLS RESOURCE
CLIENT INTAKE FORM
(please print legibly)**

Name:

Date:

Gender:

Marital Status:

Birthdate:

Ethnicity/Language:

Address:

Phones: H:

O:

C:

Primary Care Physician/Provider:

Psychiatrist:

Person Making Referral:

Current Medications:

Medication	Dose (milligrams)	How often?	For what?

1. Education: (check highest level)

completed grade _____

finished high school

some college

associate's degree

bachelor's degree in: _____ (major)

post-graduate study: _____ (degrees/fields)

OVER----->

2. Mental health problems among relatives (immediate family, cousins, uncles, aunts, grandparents)
(Check all that apply)

- Depression Anxiety Drug or alcohol problems
 Schizophrenia Bipolar disorder (manic-depression) Alzheimer's disease
 Other (please describe): _____

3. Your current health problems: (Check all that apply)

- thyroid problems Heart disease High blood pressure PMS
 Strokes Seizures headaches other neurological problems
 Other (please describe): _____

4. Your preference for telephone contacts from us:

a. On which phone would you like to receive calls: (please initial)

- home office cell other (specify): _____

b. What information would you like us to leave in messages: (please initial all that apply)

- caller's name and number
 information identifying Dr. Yoman as a psychologist and you as a client
 the reason for the call
 detailed private information about you and your condition
 other (specify): _____

c. Signature: The above reflects my preferences for telephone contacts from Dr. Yoman and Life Skills Resource.

Signed: _____
(client)

(date)