Social Work Intake Form

CLIENT INFORMATION

Full name: _____ Date of birth: _____ dd / mm / yyyy

Patient identifier (if known): _____ Sex: _____

Gender: _____ Preferred pronouns: _____

Email: _____ Contact number: _____

Address:

EMERGENCY CONTACT

Contact #1

Full name: _____ Relationship: _____

Contact number: _____

Contact #2

Full name: _____ Relationship: _____

Contact number: _____

CAREGIVER/LEGAL GUARDIAN INFORMATION

*If the client does not require a caregiver or legal guardian, please move on to the next section.

Full name: _____ Date of birth: _____ dd / mm / yyyy

Relationship: _____ Email: _____

Contact number: _____

Address:

City: _____ State: _____

Zip code: _____

PERSONAL HEALTH AND WELL-BEING

Client concerns or symptoms:

Current/ previous diagnoses (including mental health diagnosis):

Current medication/s:

Family medical history (include family mental health history):

Describe your sleeping pattern:

Describe your exercise pattern:

Do you use cigarettes, tobacco products, alcohol or recreational drugs?

◯ Yes ◯ No

If yes, which ones and how often?

Rate the following from 1 (best) to 5 (worst) if applicable:

The quality of your social relationships:

◯ ◯ ◯ ◯ ◯
1 2 3 4 5

The satisfaction of here romantic relationships

◯ ◯ ◯ ◯ ◯
1 2 3 4 5

OTHER FAMILY INFORMATION

*If the client is 18 and over, please move on to the next section

Is this child/ adolescent adopted?

◯ Yes ◯ No

If yes, at what age was he/she adopted?:

If yes, does he/ she know of the adoption?:

Please list all the persons living in the home with the child/adolescent whom we will be evaluating.

Name of current resident: _____ **Age:** _____

Relationship to child/adolescent: _____ **Name of current resident:** _____

Age: _____ Relationship to child/adolescent: _____

Name of current resident: _____ Age: _____

Relationship to child/adolescent: _____ Name of current resident: _____

Age: _____ Relationship to child/adolescent: _____

Name of current resident: _____ Age: _____

Relationship to child/adolescent: _____ Name of current resident: _____

Age: _____ Relationship to child/adolescent: _____

Are the child/adolescent's parents separated or divorced?

◯ Yes ◯ No

If yes, answer the following questions:

When did the separation occur (month/year)?:

Who has legal custody?: _____

When was the divorce final (month/year)?:

Who has physical custody?: _____

EMPLOYMENT

Select one:

◯ Employed ◯ Unemployed ◯ Self-employed ◯ Other

Occupation: _____ **Company name:** _____

Industry: _____ **Company address:** _____

City: _____ **State:** _____

Zip code: _____

On a scale from 1 (best) to 5 (worst), rate the satisfaction of your workplace:

◯ ◯ ◯ ◯ ◯

1 2 3 4 5

Client's name: _____

Client's signature:

Date: _____ dd / mm / yyyy