Social Work Intake Form

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Client information

Full name:

Date of birth:

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:

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:

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: