KHALIL CENTER

Client Intake Form

Please note that any and all information you provide will be kept confidential and in congruence with HIPPA & the Illinois Confidentiality Act.

Name:_____ Date:_____

DOB(mm/dd/yyyy):_____ Age:_____ Sex: Male ☐ Female ☐

Address:_____

City:_____ State:_____ Zip Code:_____

May we send mail to the above address? Yes ☐ No ☐

Relationship Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Please provide only numbers at which you give us permission to call.

Home: (_____) _____-_____ May leave a detailed message? X yes ___no

Work: (_____) _____-_____ May leave a detailed message? ___yes ___no

Cell: (_____) _____-_____ May leave a detailed message? ___yes ___no

Email Address: _____

May we send emails to the above address? Yes ☐ No ☐

Occupation:_____

Employer:_____

Highest Level of Education:_____

Who may we thank for referring us to you? _____

IN CASE OF EMERGENCY

Contact Person in case of emergency: _____

Relationship:_____ Telephone #: (_____) _____-_____

In order to bill your Insurance, we need your authorization. Your signature below also attests to the fact that you will be take responsibility for any fees that your insurance does not cover.

Release of Information: I authorize the release of any medical information needed to process this claim.

_____

Siganture Date

MEDICAL HISTORY

Primary Care Physician:_____ Telephone #:_____

List any medical problems:

_____

_____

List any medical hospitalizations:

_____

_____

_____

Please list all medications you have been prescribed for medical reasons:
(Name of medicine, dose, reason, prescribed by, date began)

_____

_____

Known food allergies:_____

SUBSTANCE ABUSE

Have ever had a problem with alcohol or drugs? N☐ Yes☐
(describe)_____

How often do you Smoke? (Circle):

Never	
Monthly	How many:_____
Weekly	How many:_____
Daily	How many:_____

Drink Alcohol (Circle) ?

Never	
Monthly	How much:_____
Weekly	How much:_____
Daily	How much:_____

Other drugs?: never☐ monthly☐ weekly☐ daily☐
(describe)_____

PSYCHIATRIC HISTORY

Have you ever been given a psychiatric diagnosis?

☐ No ☐ Yes: (describe) _____

Have you ever had any counseling, psychiatric or psychological services?

☐ No ☐ Yes: (Where, Therapist name, reason for treatment and termination)

_____

_____

_____

Please list all medications you are prescribed for psychiatric reasons:
(Name of medicine, dose, reason, prescribed by, date began)

_____

_____

Hospitalizations (psychiatric or substance abuse-give place and year):

FAMILY HISTORY

Family General History (e.g. parental occupation, number of siblings, relationship with family, etc.):

Mental illness? ☐ No ☐ Yes (who, describe) _____

Substance abuse? ☐ No ☐ Yes (who, describe) _____

Suicide? ☐ No ☐ Yes (who, describe) _____

General Social History (current social supports, social functioning, intimate relationships):

What are your goals for therapy?