In-take Date _____/_____/_____ Referral Source: _____

In-take Therapist: _____ Client Number: _____

PERSONAL INFORMATION

Name: _____ Date of Birth: ____/____/_____ Age: _____ Gender: M / F / _____

SSN: _____ Primary Language: _____

Home Address: _____ City: _____ State _____ Zip: _____

CONTACT INFORMATION (✓ The Box of Your Preferred Contact Method)

If Minor, Contact Person: _____ Relationship to Client: _____

☐Home: _____ ☐Mobile (Text Msg ☐): _____ ☐Email: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

EDUCATION / OCCUPATION INFORMATION

Enrolled: Y / N if Yes, School: _____, Grade/Graduation Year: ____, Highest Grade Completed: _____

Occupation: _____ Employer: _____ Hours/Days of Work: _____

MARITAL INFORMATION

Marital Status: _____, As of ____/____/_____ Years Married: _____ Name of Spouse: _____

Previously Married: Y / N If Yes, How Many Times: _____ Dates (or Lengths) of Marriages: _____

Children:
Name: _____ Age: ____ Name: _____ Age: ____ Name: _____ Age: ____

FAMILY INFORMATION

Parent's Marital Status: _____ Years Married: ____ Date Separated/Divorced ____/____/____ Remarried: Mom / Dad

Mother's Name: _____ If deceased, Year: _____ Father's name: _____ If deceased, Year: _____

Sibling: _____ Age: ____ Sibling: _____ Age: ____ Sibling: _____ Age: ____

MEDICAL INFORMATION

Reason for Contacting Revive: _____

History of Therapy: Y / N if Yes, when and Reason: _____

Medical Conditions/Diagnoses: _____

Allergies: _____ Medications: _____