Social Work Intake Form

Client information	
Full name:	**Date of birth:**
Patient identifier (if known):	**Sex:**
Gender:	**Preferred pronouns:**
Email:	**Contact number:**
Address:	**City:**
State:	**Zip code:**
Emergency contact	
Contact #1	
Full name:	
Relationship:	Contact number:
Contact #2	
Full name:	
Relationship:	Contact number:
Caregiver/ legal guardian information	
Full name:	
Relationship:	**Date of birth:**
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:	
The satisfaction of here romantic relationships:	
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? Answer:	
If **yes**, does he/ she know of the adoption? Answer:	
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)? Answer:	
When was the divorce final (month/year)? Answer:	
Who has legal custody? Answer:	
Who has physical custody? Answer:	

Employment	
◯ Employed ◯ Self-employed ◯ Unemployed ◯ Other:	
Occupation:	Industry:
Company name:	
Company address:	
City:	
State:	
Zip code:	
On a scale from 1 (best) to 5 (worst), rate the satisfaction of your workplace:	
Client's name:	
Client's signature:	**Date:**