The Arbor Center
Intake Form

Name_____ Date of Birth _____

Address _____

City _____ State _____ ZIP _____

Email_____

Home phone_____ Cell_____Work_____

Emergency Contact _____ Phone_____

Relationship to Client_____

Presenting problem & date first occurred_____

_____

Psychiatric hospitalizations & dates _____

Medications_____

_____

Prescribing psychiatrist _____ Phone _____

Describe any of the following symptoms you are currently experiencing:

Depression _____

Suicidal ideation _____

Sleep difficulties _____

Loss or increase in weight/appetite_____

Pattern of alcohol use _____

Pattern of drug use_____

Family history of substance abuse or alcoholism_____

Previous Therapy

Name of therapist _____

Dates treated _____