

Social Work Intake Form

Section 1: Client Information						
First Name	Last Name	Date of Birth	Patient Identifier (If known)			
Gender	Preferred Pronouns	Email	Preferred Phone Number			
Address		City	State	Zip Code		
Section 2: Emergency Contact						
Full Name		Relationship	Contact Number			
Full Name		Relationship	Contact Number			
Section 3: Caregiver/Legal Guardian Information						
If the client does not require a caregiver or legal guardian, please move on to Section 4.		First Name	Last Name			
Date of Birth	Relationship	Email	Preferred Phone Number			
Address		City	State	Zip Code		
Section 4: Personal Health and Wellbeing						
Client Concerns						
Medication						
Family History (include family mental health history)						
Current/Previous Mental Health Diagnoses						
Rate the following, if applicable: (1-best to 5-worst)						
The quality of your social relationships		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
The satisfaction of your romantic relationships		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Client Information			
First Name	Last Name	Date of Birth	Gender
Section 4: Personal Health and Wellbeing (continued)			
Describe your sleeping patterns			
Describe your exercise patterns			
Section 5: Other Family Information			
If the client is 18 and over, please move onto Section 6			
Is this child/adolescent adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, at what age was he/she adopted? _____			
If Yes, does he/she know of the adoption? _____			
Please list all persons living in the home with the child/adolescent whom we will be evaluating			
Names of Current Residents	Age	Relationship to Child/Adolescent	
Are the child/adolescent's parent separated or divorced? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, answer the following questions:			
When did separation occur (month/year)? _____			
When was the divorce final (month/year)? _____			
Who has legal custody? _____			
Who has physical custody? _____			
Section 6: Employment			
<input type="checkbox"/> Employed <input type="checkbox"/> Self Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Other _____			
Occupation	Industry	Company Name	
Company Address	City	State	Zip Code
Rate the satisfaction of your workplace from 1(best) to 5(worst): <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5			
Signature		Date	