



# UTAH PSYCHOLOGICAL ASSOCIATES, LLC

## CLIENT INTAKE FORM

Client Name: \_\_\_\_\_ Today's date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Complete Address: \_\_\_\_\_  
Street City State Zip

Primary Phone: ( ) \_\_\_\_\_ Home Work Cell OK to text? Y N

Email address (where account statements will be sent): \_\_\_\_\_

If client is under 18, parent/guardian name(s): \_\_\_\_\_

Parent Address (if different than above): \_\_\_\_\_

Parent Phone (if different than above): ( ) \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Relationship: \_\_\_\_\_

How did you learn about us? \_\_\_\_\_

Which of our therapists are you seeing? (Please circle one):

Tim Buck CMHC Brooklyn Cook ACMHC Richard Ellsworth PhD Shaun Fesler CMHC  
Kevin Kirschenmann LCSW Casey Mangnall PsyD Jen Morrill PhD Patty Weaver LCSW

Primary Insurance Company: \_\_\_\_\_

Membership/ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Name of insurance holder: \_\_\_\_\_

Insurance holder's date of birth: \_\_\_\_\_ Relation to client: \_\_\_\_\_

Insurance holder's address (if different than above): \_\_\_\_\_

If you also have secondary insurance coverage, please check the box and provide that information in the section noted on the last page of this form.

Do you have EAP pre-approval? Yes No Authorization #: \_\_\_\_\_

Number of sessions: \_\_\_\_\_ Effective Dates: \_\_\_\_\_

**NOTE:** EAP billing still requires that you provide full insurance information above

If you are using a form of payment other than insurance, please describe: \_\_\_\_\_

Briefly describe why you are here: \_\_\_\_\_

Please list any psychologists/therapists/psychiatrists client has seen in the last 2-3 years:

Name	Dates	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any relevant psychological conditions or diagnoses the client has:

Condition/Diagnosis	When diagnosed?	Still a problem?
_____	_____	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>

Please list any serious medical conditions or injuries client has previously had:

Condition	When diagnosed?	Still a problem?
_____	_____	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>

Please list any relevant medications client takes currently, or has taken in the last few years:

Medication	Date started	Reason	Currently taking?
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>

Has the client have ever had a problem with drugs or alcohol? Yes No

If yes, please describe: \_\_\_\_\_  
 \_\_\_\_\_

Has the client ever been involved with the legal system (arrested/probation/parole)? Yes No

If yes, please describe: \_\_\_\_\_  
 \_\_\_\_\_

Please list any people/professionals/agencies with whom you would like your therapist to communicate (you will be asked to sign a release):

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If you have secondary insurance information, please provide that here:

Secondary Insurance Company: \_\_\_\_\_

Membership/ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Name of insurance holder: \_\_\_\_\_

Insurance holder's date of birth: \_\_\_\_\_ Relation to client: \_\_\_\_\_

Insurance holder's address (if different than above): \_\_\_\_\_

Any additional comments for your therapist: \_\_\_\_\_

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