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 Amberly Christensen ACMHC Brooklyn Cook CMHC 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?
_____	_____	☐
_____	_____	☐
_____	_____	☐

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

Condition	When diagnosed?	Still a problem?
_____	_____	☐
_____	_____	☐
_____	_____	☐

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

Medication	Date started	Reason	Currently taking?
_____	_____	_____	☐
_____	_____	_____	☐
_____	_____	_____	☐
_____	_____	_____	☐

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):

_____

_____

_____

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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