Sound Minds Intake Application Form

Client Information

- **Full Name:** _____
- **Date of Birth:** _____
- **Gender:** □ Male □ Female □ Other _____
- **Phone Number:** _____
- **Email Address:** _____
- **Preferred Method of Contact:** □ Phone □ Email □ Text
- **Address:** _____
- **City:** _____
- **County:** _____
- **Zip Code:** _____
- **Emergency Contact Name:** _____
- **Emergency Contact Phone Number:** _____

Insurance Information (if applicable)

- **Primary Insurance Provider:** _____
- **Policy Number:** _____
- **Secondary Insurance (if applicable):** _____
- **Policy Number:** _____

Referral Source (check all that apply):

- □ Self-Referral
- □ Family/Friend
- □ Healthcare Provider (Doctor, Therapist, etc.)

- □ Community Agency (e.g., homeless shelter, recovery center)
- □ Court/Probation Referral
- □ Other (Please specify): _____

Presenting Concerns

- **What are the primary issues you are seeking help with?**
- **Have you ever received counseling or mental health services before?** □ Yes □ No If yes, please describe:

Medical History

- **Do you have any current medical conditions?** □ Yes □ No If yes, please describe:
- **Are you currently on any medications?** □ Yes □ No If yes, please list:
- **Have you ever been hospitalized for mental health reasons?** □ Yes □ No If yes, when and for what reason?

Housing & Living Situation

- **Current living situation:** □ Stable housing □ Temporary housing □ Homeless □ Other: _____
- **Do you require assistance with housing?** □ Yes □ No If yes, please describe:

Employment & Financial Information

- **Are you currently employed?** □ Yes □ No If yes, what is your occupation?
- **Do you need help with job placement or vocational support?** □ Yes □ No
- **Are you receiving any financial assistance (e.g., SSI, SSDI)?** □ Yes □ No If yes, what type?

Consent for Services

By signing below, I consent to receiving counseling and related services from Sound Mind Counseling Services. I understand that all information shared is confidential, except in cases where disclosure is required by law. I also consent to the sharing of necessary information with appropriate service providers or agencies involved in my care.

Signature of Client: _____ **Date:** _____

Staff Use Only

- **Assigned Therapist/Case Manager: _____**
- **Date of Initial Intake: _____**
- **Type of Services Requested:** □ Individual Therapy □ Group Therapy □ Both
- **Notes/Additional Information:**