Sharyn Schreiber Pinney, LCSW

Client Intake Form

PLEASE PRINT

Personal Information

Name		Date of Birth			Social Security Number		
Last	*First*	*MM*	*DD*	*YYYY*	*###*	*##*	*####*

Parent/Guardian Information (required if client is a student or minor)

Mother'/Guardian's Name	Telephone	Email*
Father/Guardian's Name	**Telephone**	**Email***
Does minor live with both parents? ☐ **Yes** ☐ **No**	*If **No**, bring a copy of legal document (divorce decree, court order, etc) authorizing parent/guardian to seek treatment, as required by Texas law*	

**Please provide email address only if you consent to being contacted via email*

Health Care Provider Information

Primary Care Physician	Telephone
Psychiatrist	**Telephone**
Other (RD, PhD, LMFT, etc)	**Telephone**
Referred by	**May I acknowledge referral?** ☐ **Yes** ☐ **No**

Presenting Problems

Please state the reasons you are seeking therapy _____

Have you sought help for these problems or issues? ☐ **Yes** ☐ **No** *If **Yes**, please indicate name of professional seen, medications taken, and effectiveness of treatment*

Sharyn Schreiber Pinney, LCSW
Client Intake Form, continued

PLEASE PRINT

Medical History

Are you currently under a physician's care? ☐ **Yes** ☐ **No** **Physician** _____

Please list any past or present medical conditions for which treatment was received:

_____

_____

_____

_____

_____

_____

_____

_____

Current Medications (include prescription and over-the-counter medications)

Name	**Dosage**	**Name**	**Dosage**