ASSESS BELIZE
Psychological Testing & Therapy Services

# Client Intake Form

Name of Client:_____ Date:_____
DD/MM/YY

Date of Birth: _____ Age: _____
DD/MM/YY

Gender: _____

Preferred pronouns (if applicable) :_____

Relationship Status:_____

Religion : _____

Home Address;_____

Phone Number:_____

Email Address:_____

Emergency Contact Name:_____ Relationship: _____

Emergency Contact Number: _____

If Client is under 18 years of age:

Name of Parent/Guardian #1: _____ Relationship: _____

Phone Number: _____ Email Address: _____

Name of Parent/Guardian #2: _____ Relationship: _____

Phone Number: _____ Email Address: _____

Is it okay to communicate with you via text/ Whatsapp? Yes ☐ No ☐

Is it okay to communicate with you via email? Yes ☐ No ☐

Mental Health History:_____

Physical Health History:_____

Primary Care Physician _____ Phone Number_____

Psychiatrist _____ Phone Number _____

Are you currently on any medications? Yes ☐ No ☐

If yes, please list _____

Any past medications? _____

Have you been in therapy previously? Yes ☐ No ☐

If yes, with whom and when? _____

What was the primary reason at that time?_____