

The Coche Center **Client Intake Information**
(Completed During Initial Consultation)
Check list: HIPPA, How we operate, Data base, Client intake,
Credit card info, Treatment plan to follow.

Name: _____ **Date:** _____ **Clinician:** _____

I. Symptom Inquiry

Month and Year symptom first appeared _____

Have symptoms recurred? _____ Frequency _____

Other professionals involved (give name, relationship, phone number for physicians, lawyers, schools, etc.)

II. Mental Health Assessment

Past Mental Health History:

Psychological Assessment _____

Psychotherapy (date, therapist, outcome) _____

Special Schools/agencies in past _____

Reason for Referral in your own words:

What are your goals for psychotherapy (list specific goals)

III. Disposition

Therapist (primary) _____

Medication ? Physician? _____

DSM IV Diagnosis Axis I:

AXIS 2

AXIS 3

AXIS 4

AXIS 5 _____

Diagnosis for INSURANCE _____