AKRON FAMILY INSTITUTE, INC.
INITIAL INTAKE

Date: ___________________

Therapist: _____________________
Referral Source: ________________
DSM-IV: _______________________

CHART #: ________________

CLIENT: ____
(Last) (First) (Middle) (Birth Name)

*DATE OF BIRTH:*_____________________*AGE:*_____________*SEX:*______________

*ADDRESS:*____

____

PHONE #: Home: _______________________Work:__________________ext____

Pager: _______________________Cell: _________________________

E-Mail Address: ____

*EMPLOYER/OCCUPATION:*______________________________________

*SCHOOL:*_______________________________________*GRADE:*________________

*SELF IDENTIFIED RACIAL/ETHNIC GROUP:*_____________________________

MARITAL STATUS: Single____ Married____ Divorced____ Separated____ Other____

NUMBER OF MARRIAGES: ______

IN CASE OF EMERGENCY

NAME: ____

RELATIONSHIP: _______________________________________

PHONE NUMBER: ______________________________________

ADDRESS: ____

____

SPOUSE/SIGNFICANT OTHER (if applicable)

NAME: ____
(Last) (First) (Middle) (Birth Name)

*DATE OF BIRTH:*____________________*AGE:*____________*SEX:*____________

*ADDRESS:*____

____

PHONE #: Home: ______________________Work:___________________ext____
Pager: ______________________Cell: ____________________

*EMPLOYER/OCCUPATION:*____

*SCHOOL:*_____________________________________*GRADE:*_______________

*SELF IDENTIFIED RACIAL/ETHNIC GROUP:*______________________________

MARITAL STATUS: Single____ Married____ Divorced____ Separated____ Other____

NUMBER OF MARRIAGES: ______

HOUSEHOLD MEMBERS **–** Include All Adults and Children in home not listed above

NAME	DATE OF BIRTH	RELATIONSHIP TO CLIENT

SIGNIFICANT OTHERS – Not currently living in household with client

NAME	DATE OF BIRTH	RELATIONSHIP TO CLIENT

Client Name: ______________________________
Client ID#: ______________________________
Therapist Name: ___________________________

PARENT(S) OR LEGAL GUARDIAN **–** If client is under 18 years of age

MOTHER: ____

*DATE OF BIRTH:*_________________________ *AGE:*______________

*ADDRESS:*____

____

*EMPLOYER/OCCUPATION:*__________________________________

PHONE #: Home: __________________ Work:______________ ext____

Pager: __________________ Cell: _______________

FATHER: ____

*DATE OF BIRTH:*_________________________ *AGE:*______________

*ADDRESS:*____

____

*EMPLOYER/OCCUPATION:*__________________________________

PHONE #: Home: __________________ Work:______________ ext____

Pager: __________________ Cell: _______________

Client Name: ______________________
Client ID#: ________________________
Therapist Name: ____________________