Evaluation Intake Information

Name: _____ _____

(Last) (First)

Address: _____

_____

_____

Phone: _____ **Okay to leave a message?** Yes No

E-mail: _____

Date of Birth: ___ / ___ / _____

Occupation: _____

Are you currently taking any medications? If yes, please list below with the current dosage:

_____ _____ _____

Date of last doctor's visit (Month / Year): _____ / _____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

OHP Client ID #: _____

Have you been to counseling before? Yes No

Prior Diagnoses: _____

OVER

Do you use any recreational drugs? Yes No **Type:** _____

How many alcoholic drinks do you have per week? None 1-3 4-6 6-10 10+

How did you hear about me?

I did a Google Search *(search term used):* _____

I went directly to a website *(name of website):* _____

I was referred by: _____

Other: _____

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