____
Last, First Name of Client (Print)

VIATRU Life Solutions

Intake for Counseling/Psychotherapy

CLIENT INFORMATION			
Legal Name (First, Middle, Last)	Date of Birth (DOB)	Age	Social Security Number

Preferred Name	Email Address
Place of Employment/Academic Institution	Job Position/Academic Level

Marital Status (select one)

Single Engaged Legally Married (# of times____) Separated Widowed (# of years____) Divorced (# of times____)

Physical Address	City	State	Zip

Preferred Contact Number	Alternate Contact Number

Please mark acceptable methods of contact? (select all that apply)

Preferred Number Alternate Number Text Email

Emergency Contact Name	Contact Number	Relationship to You

Referred By	If not referred, how did you hear about Viatru?
Highest Grade Completed (select one) 0 1 2 3 4 5 6 7 8 9 10 11 12 13+	Are you hearing impaired? Yes or No

Race

Black/African American White Asian American Indian/Alaska Native
Native Hawaiian or Pacific Islander Decline to Answer

Please help us understand why you are currently seeking services (mark all that apply):

____Anger	____Depression	____Christian Counseling	____Suicidal Thoughts
____Loss/Grief	____Stress	____Finances	____Self Injurious Behavior
____Guilt/Shame	____Family Issues	____School Issues	____Health Condition
____Fear/Phobia	____Communication	____Sleep Difficulties	____Crying Spells
____Abuse History	____Divorce/Separation	____Body Image	____Sexual Dysfunction
____Parenting Issue	____Peer Issues	____Work Related Issues	____Infertility
____Pornography Addiction	____Premarital Counseling	____Domestic Violence	____Mood Fluctuations
____Drug/Alcohol Abuse	____Trauma	____Sexual Orientation	____Anxiety
____Relationship Issues	____Other (please specify): ______________________________		

Are the issues you are currently experiencing related to:

a.) Employment (select one)
Yes or No

b.) Auto Accident (select one)
Yes or No

c.) Other Accident (select one)
Yes or No

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HEALTH AND WELLNESS

Have you ever been seen by a therapist, pastor, lay counselor, or psychiatrist before?
Yes or No

If yes, reason for service?	Date(s) of Service	Person(s) Seen
If yes, reason for service?	Date(s) of Service	Person(s) Seen
If yes, reason for service?	Date(s) of Service	Person(s) Seen

Have you ever been diagnosed by a qualified mental health professional? Yes or No	If yes, by whom: ______________________________ When: ____________________________________ Diagnosis: ____________________________________
Have you ever verbalized a suicide threat or attempted suicide before? Yes or No	If yes, please provide the following information. ▪ Type of Threat (choose one): Written/ Verbal /Attempt ▪ Date: _______________
	If yes, provide the following information. ▪ Type of Threat (choose one): Written/ Verbal /Attempt ▪ Date: _______________

List any medications you are currently taking. Please include the frequency, dose, and the name of the prescribing physician.

Medication	Dose/Frequency	Prescribing Physician

TRAUMATIC EXPERIENCES (mark all that apply)

____Physical Abuse ____Domestic Violence ____Victim of Crime ____Child Sexual Abuse

____Natural Disaster ____Medical Injury/Procedure ____Kidnapping ____Rape/Sexual Assault

____Community Violence ____Neglect/Deprivation ____Accident ____Human Trafficking

____School Violence ____Family/Child Separation Other (please specify): ________________________

SUPPORTS AND COPING (mark all that currently apply)

____Supportive Family ____Friends ____Walk/Jog/Run ____Journaling/Writing

____Eating Healthy ____Prayer/Meditation ____Volunteering ____Fitness Classes

____Spirituality ____Social Connections ____Listening to Music ____Parenting Support

____Sobriety Circle/Group ____ Athletics Other (please specify): ________________________

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INSURANCE AND BILLING		
Name of Insurance Provider (Primary)	Primary Policy Number	Group Number
Name of Policy Holder (Primary)	Policy Holder DOB	Relationship to Client
Name of Insurance Provider (Secondary)	Secondary Policy Number	Group Number
Name of Policy Holder (Secondary)	Policy Holder DOB	Relationship to Client

**We require clients to keep an active credit card on file in accordance with our billing policy.*

PLEASE READ CAREFULLY: Viatru Life Solutions, LLC's billing policy requires payments to be made on the date of service, unless other arrangements are made prior to the scheduled appointment. Credit/Debit cards on file may be billed for payments, deductibles, fees, or balances for which the identified client is responsible. Co-pays are required on the date of service.

Signature of Card Holder, Authorizing Payment	Date Signed	Initials of Witness
Card Holder's Name (Printed)		Billing Zip Code of Card Holder
Card Number	Expiration Date	3 Digit # on the Back

Type of Card (select one)

Visa Master Card Discover American Express Debit

MINOR CLIENT INFORMATION		
Please complete this section for clients 19 and under ONLY.	Parent/Guardian's Name	Parent/Guardian's Number
	Parent/Guardian's Name	Parent/Guardian's Number
# of People in Household	# of Siblings	Age(s) of Siblings

Signature of Client (14 and older) ______ Date ______

Signature of Parent/Guardian (Required if Client is a Minor) ______ Date ______

Therapist Completing Intake Interview ______ Date ______