



**LEGACY**

MENTAL HEALTH CENTER

# Client Intake Form for Adults



## Client Information:

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Date

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Provider Name

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Client Name

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Date of Birth

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Home address line 1: Street, Unit (if applicable)

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Home address line 2: City, State, Zip Code

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Email

Phone:

\_\_\_\_\_

Home

\_\_\_\_\_

Cell

\_\_\_\_\_

Work

May We Leave Messages:

\_\_\_\_\_

Home (Y/N)

\_\_\_\_\_

Cell (Y/N)

\_\_\_\_\_

Work (Y/N)

\_\_\_\_\_

Referred by, (if applicable)

\_\_\_\_\_

Employer

**Emergency Contact:**

\_\_\_\_\_

Name

\_\_\_\_\_

Relationship

\_\_\_\_\_

Phone Number

\_\_\_\_\_

Signature of Client

\_\_\_\_\_

Date