



*Jennifer H. Harris, Psy.D. ~ Clinical Psychologist*  
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## Intake Form

NAME OF CLIENT: \_\_\_\_\_ DOB: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

Cell Ph: (    ) \_\_\_\_\_ Other Ph: (    ) \_\_\_\_\_

Is it okay to text you on your cell phone to leave messages?    YES \_\_\_\_\_    NO \_\_\_\_\_

If using Tricare, please include sponsor's SSN: if using MHN, please include Sponsor's name & birthdate: \_\_\_\_\_

Email: \_\_\_\_\_

HIGHEST GRADE/DEGREE: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

PERSON AND TEL. NO. TO CALL IN EMERGENCY: \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_

OCCUPATION/POSITION: \_\_\_\_\_

INSURANCE INFO: \_\_\_\_\_

MEDICAL DOCTOR(S): \_\_\_\_\_ PHONE(S): \_\_\_\_\_

PAST/PRESENT MEDICAL CARE (Specify: major problems, accidents, hospitalizations):  
\_\_\_\_\_

CURRENT MEDICATIONS: \_\_\_\_\_

PAST/PRESENT COUNSELING/PSYCHOTHERAPY/PSYCHIATRIC HOSPITALIZATION:  
\_\_\_\_\_

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (any addiction, AA/NA, etc.):  
\_\_\_\_\_

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, VIOLENCE, SUICIDE:  
\_\_\_\_\_

PRESENTING PROBLEM/AREAS OF CONCERN:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_