



RBH Client Intake Form

Welcome to Renaissance Behavioral Health.

Please complete this form as accurately as possible. This information helps us provide personalized care. All information is confidential.

Section 1: Personal Information

- Full Name: _____
- Date of Birth: ____ / ____ / ____
- Age: _____
- Gender: Male Female Non-binary Prefer not to say
- Preferred Pronouns: He/Him She/Her They/Them Other: _____
- Address: _____
- City / State / ZIP: _____
- Phone Number: _____
- Email Address: _____
- Preferred Method of Contact: Phone Email Text
- Emergency Contact Name: _____
- Relationship: _____
- Emergency Contact Phone: _____

Section 2: Insurance & Payment

- Insurance Provider: _____
- Policy Number: _____

- Group Number: _____
- Primary Insured Name: _____
- Relationship to Client: Self Parent Spouse Other: _____
- Payment Method: Insurance Self-Pay Other: _____

Section 3: Referral Information

- Referred By: Self Family Physician Other: _____
- Primary Reason for Seeking Treatment: _____
- Previous Treatment History: Yes No
 - If yes, please list provider, dates, and type of therapy:

Section 4: Mental Health & Medical History

- Current Medications (Name, Dosage, Prescribing Provider):

- Allergies (Medication, Food, Environmental): _____
- Current or Previous Diagnoses: _____
- Previous Hospitalizations or Residential Treatment: Yes No
 - If yes, please describe: _____
- Past or Present Mental Health Concerns (check all that apply):
 Depression Anxiety PTSD Bipolar OCD Other: _____
- Substance Use History (Alcohol, Drugs, Tobacco – frequency, duration):

- Family Mental Health/Substance Use History: _____

Section 5: Lifestyle & Support

- Living Situation: Alone With Family Other: _____

- Employment/School Status: _____
- Support System (Family, Friends, Community, Faith): _____
- Hobbies/Interests/Coping Skills: _____

Section 6: Safety & Risk Assessment

- History of Self-Harm or Suicidal Thoughts: Yes No
 - History of Harm to Others or Violent Behavior: Yes No
 - Current Legal Issues: Yes No
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Section 7: Goals & Preferences

- Primary Goals for Treatment: _____
- Preferred Therapy Types: Individual Group Family Other: _____
- Additional Notes for Care Team: _____

Client Signature: _____

Date: _____

Staff Intake Signature: _____

Date: _____