INTAKE FORM

Date : _____

Client's Full Name : _____ SSN : _____

Spouse/Parent/Guardian's Full Name : _____

Address : _____

Home phone : _____ Occupation : _____
Work phone : _____ Employer : _____
Cell phone : _____

Date of Birth : _____ Age _____ Sex : ☐ Male ☐ Female

Race : _____ Education Completed : _____

Religious affiliation: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Emergency Contact : _____
Emergency Contact's Phone # : _____

Previous Counseling: ☐ Yes ☐ No Name of Counselor: _____

What brings you to counseling at this time?

_____

_____

Primary Physician : _____ Office Phone : _____

Current Medical Conditions : _____

Insurance Coverage: ☐ Yes ☐ No Name of Company : _____

Name of Insured : _____ ID # : _____

Name of Insured's Employer : _____ Insured's DOB : _____

(Please provide us with your insurance card so we may photocopy)

Referred by (Please circle all that apply) :

Former client	Friend/Relative	Clergy or MAP	Publicity (brochures, google, etc)
Insurance	Other Professionals	Self Referral	Employee Assistance Programs