Purpose Counseling and Consulting, LLC

Client Information Intake Form

Name _____ ___ _____

First MI Last

Date of Birth ____/___/_____

Address _____ _____ ___ _____

City St Zip code

Email_ _____

Home Phone (____) _____ Cell phone (___) _____

Preferred Contact: Email __ Cell___ Home phone___ (please check)

Medical Information:

Primary Care Physician: _____ Phone: _____

Psychiatrist _____ Phone_____

Current medications

_____

_____

Presenting Concerns (circle all that apply)

Anger Management Anxiety Depression Substance Abuse Trauma

Disordered Eating Grief /loss Divorce Self Esteem Chronic Pain

Family Concerns Sleep Life Stressors Identity Issues

Other_____