

Confidential Intake Form

Today's Date _____

Personal Information

Name _____ Phone _____ Email _____

Address _____

city state zip

Date of Birth _____ Age _____

Family Status _____ If married, how long? _____

Occupation _____ Employer _____

Do you attend church? _____ if so, where? _____

How would you describe your overall health?

Are you taking any medications currently? If so, please list _____

When were you last seen by a physician? _____

Primary Physician _____ Phone _____

Address _____

Have you ever received counseling or been hospitalized for mental health/emotional reasons? If so, please list below:

Name/Address	Dates of Treatment	Reason for termination

Spouse Info (if applicable)

Name _____ Date of Birth _____

Phone _____
Work _____ Cell _____

Occupation _____ Employer _____

Children (if applicable)

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Referral Information:

Referred by _____

Phone _____

Briefly describe your reason for seeking counseling: _____

Are there any other concerns you have currently? _____

Person to be contacted in case of emergency:

Name/Relationship to you

Phone Number

Client Signature

Parent Signature (if applicable)

Date