LINDA E. CARLOS, M.A.

Individual Psychotherapy
Marriage, Family, Child Counseling

Please fill out the following intake information as completely as possible.

Thank you.

*Date:*_____

*Client:*_____ *Parent/Spouse Name:*_____

*Birth date:*_____ *Age:*_____ *Birth date:*_____ *Age:*_____

*Social Security #*_____ *Social Security #*_____

Single ☐ *Married* ☐ *Date* _____ *Divorced*☐ *Date*_____ *Widowed* ☐ *Date*_____

*Address:*_____*City:*_____*Zip:*_____

*E-mail:*_____

*Home Phone:*_____ *Work Phone:*_____

*Employer:*_____ *Spouse's Employer:*_____

*Insurance/Employee Asst. Program:*_____ *I.D.#*_____

*Insurance Claim Address & Phone #:*_____

Children: *Full Name* *Age* *Living at home? (Y/N)*

*1.*_____

*2.*_____

*3.*_____

*Emergency Contact (Name/Phone):*_____

How were you referred to me? _____

Previous Counseling: (Who? When? How long? Outcome?)

_____

_____

*If you attend church: Name:*_____ *Pastor:*_____

Doctor: _____*Phone:*_____

*Medical Problems:*_____

*Current Medications:*_____ *Amounts:*_____

_____ *Amounts:*_____

_____ *Amounts:*_____

*Any side effects/reactions:*_____

10/07