

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:	<u>Full Name</u>	<u>Age</u>	<u>Living at home? (Y/N)</u>
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