

Heather McNally, M.S., MFT
Licensed Marriage Family Therapist
License # MFC 42294

(916) 685-5258x26
8861 Williamson Dr., Suite 40
Elk Grove, CA 95624



Please fill out this intake information as completely as possible. Thank you.

Client: _____ Birth date: _____ Age: _____

Spouse/Parent: _____ Birth date: _____ Age: _____

Address: _____ (include zip code) _____

Home Phone: _____ Work: _____ Cell: _____

Please indicate the preferred number for messages

Parent: _____ Birth date: _____ Age: _____

Address: _____

Home Phone: _____ Work: _____ Cell: _____

Client SSN _____ Spouse/Parent SSN _____

Employer: _____ Spouse's Employer: _____

Insurance/Employee Asst. Program: _____

Insurance I.D. # _____ Group # _____

Emergency Contact (Name/Phone #) _____

Status (please circle)

single married divorced widowed Date of last status change _____

Children

Full Name

Age

Living at home? (Y/N)

1. _____

2. _____

3. _____

4. _____

How were you referred to me? _____

Please briefly describe your reason for seeking counseling today, including any previous counseling you've had (who, when, how long, outcome?)

Doctor: _____ Address: _____

Phone: _____

Medical Conditions (history, current condition, changes in condition):

Current Medications (dosage, dates of initial prescriptions, name of prescribing professional):

Client's signature: _____ Date: _____

Spouse/Parent signature: _____ Date: _____

Spouse/Parent signature: _____ Date: _____