Intake Form

Personal Data Sheet

Strictly Confidential/Fill Out Completely

Date_____________________

Counselor:_________________________

Client's Name:_________________________ SSN:_______________ D.O.B: ________

Client Occupation: _______________________ Company:__________________________

Work Phone: (_____) ________________ Ext. _______ Cell Phone:_________________

Marital Status: Married ___________ How long?________

Divorced ___________ How long?________ Times Divorced: _____

Separated __________ How long?________

Widowed __________ How long?________

Single __________

Spouse/Mate's Name:________________ SSN:_________________ D.O.B: _________

Occupation: _______________________ Company:___________________________

Work Phone: (_____) ________________ Ext. _______ Cell Phone:_________________

Marital Status: Married ___________ How long?________

Divorced __________ How long?________ Times Divorced: _____

Separated __________ How long?________

Widowed __________ How long?________

Single __________

Address: _____________________________________ **Home Phone**: _______________

City:________________________________ State: __________ Zip:______________

E-mail Address:_______________________________________

Where can we leave a message for you? ___ Home Phone ___ Cell Phone ___E-mail ___ None

Children:

Name: __________________________ D.O.B ______________________ Sex:________

Name: __________________________ D.O.B ______________________ Sex:________

Name: __________________________ D.O.B ______________________ Sex:________

Name: __________________________ D.O.B ______________________ Sex:________

Your Educational Background:

Grade School 1 2 3 4 5 6 7 8

High School 1 2 3 4

College 1 2 3 4 5+

Other: ___________________

Mate's Educational Background:

Grade School 1 2 3 4 5 6 7 8

High School 1 2 3 4

College 1 2 3 4 5+

Other: ___________________

Religious Preference: Male: ___________________ Female: __________________

Previous Counseling: Where? (By whom?) _______________________________

When?______________ Number of Sessions: _________

Referred here today by?_______________________________

Name of Medical Insurance Company:_______________________

Co-pay amount: $___________________

Secondary Insurance? _________________________________

Please list any current medications you are taking: ________________________________