

INTAKE FORM

Date: _____

Last Name: _____ First Name: _____

Birthdate: _____ Age: _____

Address: _____ City/State/Zip: _____

How long at this address: _____

Home Phone: _____ Cell Phone: _____

OK to leave message? Yes No Number Preferred: Home Cell

Married Single Separated Divorced Widowed Committed Relationship

Spouse's Name: _____ Birthdate: _____ Age: _____

Date of current marriage: _____

Previous marriage(s) for husband? How many? _____ Duration of each: _____

for wife? How many? _____ Duration of each: _____

Names and ages of children: _____

Names and ages of present household members: _____

Are there any serious medical problems or physical disabilities in your immediate family (parents, siblings, children)? _____

Last Grade completed/degree(s)? You: _____ Spouse: _____

Your employer: _____ Phone: _____

Spouse's employer: _____ Phone: _____

Nearest relative not living with you: _____ Phone: _____

Whom may we thank for referring you? _____

Address: _____ Phone: _____

Whom may we contact in case of an emergency who does not reside with you? _____

Phone: _____

Briefly, how would you describe the situation or problem that brings you here: _____

What actions, if any, have you taken toward finding a solution? _____

Have you or any other family member ever received prior counseling or treatment? Yes No

If yes, whom and when? _____

What do you expect from counseling here?