



Client Intake Information

Welcome to our office. We consider it an honor to get to know you and your child, and to help you both during this time. Please read and complete the following forms. Your therapist will greet you shortly in the waiting room.

Full Name _____ **DOB** _____ **Age** _____

Racial Identification _____

Address _____ City _____ State _____ Zip _____

Social Security Number _____

Home Phone _____ Cell Phone _____

Email _____

Can messages be left at these numbers or email? (Y/N please specify) _____

Employer _____ Position _____ (Part/Full Time)

Marital Status _____ # of years married _____

Spouse's Name _____ DOB _____ Age _____

Social Security Number _____

Children - Names & Ages _____

Please indicate the individuals living in your home:

Church Affiliation (if applicable) _____

Have you received previous counseling? _____

Please indicate any medications you are taking: _____

Briefly describe the reason you are seeking counseling _____

Person to notify in case of an emergency: _____

Street Address _____ City/State _____ Zip _____

Phone # _____ Relationship to you _____

Date _____ Client Signature _____

But I am like an olive tree flourishing in the house of God; I trust in God's unfailing love for ever and ever. ~Psalm 52:8