

Client Intake Form

Today's Date: _____

Your Legal Name: _____

Your Preferred Name: _____

Date of Birth: _____ Age: _____

Home Address _____

City _____

State _____

Zip Code _____

E-Mail Address: _____ May I email you?

Yes _____ No _____

Please note: Email correspondence is not considered to be a confidential medium of communication.

Home Phone: () _____ May I leave a message? Yes No

Cell Phone: () _____ May I leave a message? Yes No

Highest Level of Education: _____

Relationship Status: Cohabiting

Divorced

Engaged

Married

Separated

Single

Widowed

Employment: Employed full-time

Employed part-time

Full-time student

Part-time student

Homemaker

Other _____

Spouse/Significant other _____ Preferred Name: _____

Client's Place of Employment _____

Work Phone _____

Are you experiencing any difficulties or concerns with your eating patterns? _____ If
so, explain: _____

Do you consume alcohol? Yes No

Do you consume more than two drinks a day? Yes No

Do you use recreational drugs or prescription drugs for recreational purposes? Yes No

How would you describe your personal strengths?

What do you consider to be some of your personal weaknesses?

What significant life changes or stressful events have you experienced recently?

Please provide a brief description of your reason for seeing a therapist: _____

Who referred you to therapist? _____

Have you ever received counseling services before? Yes No

If yes, please indicate: When? _____

For what reason? _____

Are you currently seeing another counselor? Yes No