Client Intake Form

Name: _____ Today's Date: ____/____/____

Address: _____ City: _____ State: _____ Zip: _____
Phone numbers: Home: _____ Cell: _____ Work: _____
Where would you prefer to be contacted (for any counselor follow-up?) - Circle number above
Emergency Contact: _____ Phone # _____ Relationship _____
E-mail address (if applicable): _____
Would you like to be placed on our mailing list? YES NO (please circle one)

How did you hear of my services? _____
May I send him/her a thank you for your referral? YES NO (please circle one)

1. PERSONAL INFORMATION:

Sex: _____ Date of birth: _____ Age: _____ Place of birth: _____
Highest school grade completed: _____ Certificates/degrees: _____
Employer: _____ Scope of work performed: _____
How long employed: _____

2. HOUSEHOLD INFORMATION:

Name	Relationship to you	Step (Y/N)	Gender (M/F)	Education current or completed

List any children not living in your household along with their gender and age: _____
_____

3. RELATIONSHIPS: Current Status (check one)

		How Long?			How Long?
☐	Never Married	N/A	☐	Married	
☐	Living Together		☐	Separated	
☐	Engaged		☐	Divorced	
			☐	Widowed	

Date of marriage (if applicable) _____

4. FAMILY OF ORIGIN:

My Parents are (circle one): Still Together Separated Never Married Remarried Divorced
With whom did you live growing up (circle one): Mom Dad Both Other?_____
Are either of your parents deceased? NO YES If yes, cause of death _____ how long ago? ___

Your Brothers				Your Sisters			
Name	Age		Living (Y/N)	Name	Age		Living (Y/N)

Has anyone in your family had a problem with mental problems, alcohol/ drug problems or suicide? (Current family or previous generations - close or distant) NO YES If Yes, please explain.

Losses that I have experienced in my life are...