INTAKE INFORMATION

Name____Date_____________________

Address______________________________________Date of Birth___________________

______________________________________(Include zip code)

Phone____________________________Cell_______________________________________

Work_____________________________Email______________________________________

Complete this portion if here for couple's counseling:

Name of Other______________________________Date of Birth_____________________

Employer___________________________Position__________________________________

Phone ____________________________E-Mail_____________________________________

Referral Source____

Marital Status ____single ____married ____co-habiting ____divorced

Number of children____________Age range of children______________

Previous counseling experience:

Clinician? When? How long?

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Complete if you would like to obtain insurance claim forms following your sessions:

Insured's Name___________________________Employer____________________________

Name of Insurance Plan____

Date of Birth of Insured_________________________SS#Insured____________________

Group #___________________________________Policy #____________________________