



Client Intake Form

Today's Date: ____ / ____ / ____

Your Name: _____ Soc. Sec. #: _____ - _____ - _____

___ Male ___ Female DOB: ____ - ____ - ____ Age: ____ Marital Status: ____

of Dependents: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Best Phone #: (____) _____ - _____ Email: _____

Alternate Phone #: (____) _____ - _____

Referred by: _____

Employer: _____ Supervisor: _____ How long? _____

Job Title: _____ Work Phone: (____) _____ - _____

Address: _____ City: _____ State: ____ Zip: _____

Email: _____ May we contact you at work? ___ YES ___ NO

Primary Insurance: _____ ID #: _____

Group #: _____ Subscriber: _____ Phone: (____) _____ - _____

Address: _____ City: _____ State: ____ Zip: _____

Website: _____

Spouse (parent if minor): _____

Soc. Sec. #: _____ - _____ - _____ DOB: ____ - ____ - ____ Age: ____

Employer: _____ Work Phone: (____) _____ - _____

Employer's Address: _____

Email: _____

What concern(s) brings you to counseling? _____
