CLIENT INTAKE INFORMATION

Insurance / EAP/ Fee: _____ **Therapist:_____** **Date: _____**

Focus of Service: (circle) INDIVIDUAL COUPLE FAMILY

Client Name:_____Sex:_____ Age:_____Birth Date:_____

Marital Status:_____ SS#:_____ Race:_____

Education (Highest Grade Completed):_____

Employer:_____

Home Address:_____ City:_____ State:_____ Zip:_____

☐ Home Phone: _____ May I call/leave a message at home? Yes ____ No ____

☐ Work Phone: _____ May I call/leave a message at work? Yes ____ No ____

☐ Cell Phone: _____ May I call/leave a message? Yes ____ No ____

Name of Spouse/Partner/Parent: _____ Sex:_____Age:___

Birth Date:_____ SS#:_____ Race:_____ _____

Education (Highest Grade Completed): _____Relationship to the client:_____

Address (if different):_____City: _____ State:_____Zip:_____

Home Phone:_____ Work Phone:_____ Employer:_____

Name, Birth date, Age, and Sex of other Family Members not already listed above.

Name	Birth date	Age	Sex	Relationship to client	In Household? (yes or no)
_____	_____	_____	____	_____	_____
_____	_____	_____	____	_____	_____
_____	_____	_____	____	_____	_____
_____	_____	_____	____	_____	_____
_____	_____	_____	____	_____	_____

Emergency Contact (Name and Phone #): _____