THE COUNSELING COLLABORATIVE

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Intake Information

Client Name:______________________________________ **Date:** _____________
First/Last/Middle Initial

Preferred Pronoun: ________________(he/she/them, etc)

Date of Birth: ________________ **Current Age:** ____ **Marital/Relationship Status:** _________
mm/dd/yyyy

If under 18, Parent/Guardian Name: ____

Mailing Address:____
____

Physical Address (if different from above): ____
____

Home Phone: __________________ **Cell Phone (client):** ______________________________________

Cell Phone Parent/Guardian (if applicable): ____

Permission to text client ___ **Yes** ____**No** **Signature:** _______________________ **Date:** ______

Work Number: __________________ **Email:** ___________________________________

Emergency Contact: ____ **Relationship:** _______________

Emergency Contact Phone Number: ____

Current Family Members (names, relations & ages):
____
____

Major Medical Conditions/Allergies:
____
____

Current Medications ____
____

Medications Prescribed by: ____

Primary Care Physician: ____ **Phone #:** ______________

Referred By (including self): ____

Briefly, what do you hope to gain from counseling?
____
____

Prior mental health treatment & mental health hospitalizations (providers & dates):
____

Prior Diagnosis if known: ____

Employment Status: ☐ **Full Time** ☐ **Part Time** ☐ **Not Employed** ☐ **Seasonal** ☐**Student**