

ERIN S. HOLT, M.Ed., LPC
LICENSED PROFESSIONAL COUNSELOR

Client Intake Form

Today's Date _____

Your Legal Name _____

Spouse/Significant Other _____

Client's Name (if minor) _____

Client's Date of Birth _____ Age _____

Home Address _____

City _____ State _____ Zip Code _____

Email Address _____

Phone (s) _____

Can messages be left on your phone? _____

Client's Relationship Status _____

Employment _____

How long? _____

Client's Physician' Name _____

Client's Psychiatrist's Name _____

Emergency Contact _____

Relationship to Client _____

Phone _____ **City** _____

Names of Children/Step-Children:	M/F:	Age:	Lives With:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Marital History of Client:

1st Marriage: Date Began _____ Date Ended _____
Of Children _____ Name of Spouse _____

2nd Marriage: Date Began _____ Date Ended _____
Of Children _____ Name of Spouse _____

3rd Marriage: Date Began _____ Date Ended _____
Of Children _____ Name of Spouse _____

Client's Medications:	Name	Dosage	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any current health problems client is being treated for:

Please provide a brief description of your reason to seek therapy:

Who referred you to therapist?

Have you ever received counseling services before? _____

If Yes, please indicate: When: _____

For what reason? _____

Are you currently seeing another therapist? _____