

Counseling Intake Form

Each person attending therapy should complete a separate form.

Name _____ Gender Male Female

Mailing Address _____ D.O.B. _____

Home Phone _____ Work _____ E-mail _____

How would you like to be contacted? Home Work Email Okay to leave a message? Yes No

**If client is a minor, name of parent or legal guardian* _____

Emergency Contact

Name _____ Phone _____

Relationship to Client(s): Relative (specify) _____ Spouse/Partner Other (specify) _____

History

Are you now under a doctor's care? _____ If yes, name of doctor _____

Reason for doctor's care _____

Are you taking any medication? _____ If yes, what kind? _____

Reason for medication _____ Last medical examination _____

Have you ever been hospitalized for a physical illness? _____ Describe _____

Have you ever been hospitalized for a mental illness? _____ Describe _____

Any Previous Therapy/Counseling? _____ If yes, describe, when, where, how long, what for _____

How did you hear about Plumeria Counseling Center?

Friend/Relative Physician/Therapist Website: _____ Other: _____

What do you hope to achieve with therapy? _____