

CIRCLE OF LOVE COUNSELING CENTER



CLIENT INTAKE FORM

(Please Print)

Today's date:				Primary Care Physician:			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	Occupation:		Email:		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Home Phone: ()		Cell phone: ()		
P.O. Box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone: ()		
Referred to counseling by (please check box):				<input type="checkbox"/> Dr.	<input type="checkbox"/> Church	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Internet	<input type="checkbox"/> Other			
How did you hear about Circle of Love Counseling Center?							
BACKGROUND & BILLING INFORMATION							
Person responsible for bill:		Birth date: / /	Address (if different):			Home/Cell phone: ()	
Occupation:	Employer:	Employer address:			Employer phone: ()		
Have you ever received counseling in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes Please Explain:							
Please indicate type of counseling you would like to receive:							
<input type="checkbox"/> Individual		<input type="checkbox"/> Family		<input type="checkbox"/> Couples		<input type="checkbox"/> Pre-marital	
<input type="checkbox"/> Crisis		<input type="checkbox"/> Grief & Loss		<input type="checkbox"/> Parenting Teen		<input type="checkbox"/> Depression	
<input type="checkbox"/> Anxiety		<input type="checkbox"/> Spiritual		<input type="checkbox"/> Anger			
Spouse's Name:		Address if different:		Birth date: / /	Home/Cell phone:		Occupation:
							Years Married:
Children names and ages:							
Any current medical conditions (explain):			Addiction Issues:		Grief/Loss History:		
Do you have intent to harm others? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any suicidal thoughts? <input type="checkbox"/> Yes <input type="checkbox"/> No							

IN CASE OF EMERGENCY

In case of medical emergency who can I call:	Relationship to patient:	Home/Cell phone: ()	Work phone: ()
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The above information is true to the best of my knowledge.

Patient/Guardian signature:	Date:
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