# Intake

Name_____ Date_____

Age_____ DOB_____ Marital Status_____

Address:_____

Home Phone_____ Cell Phone_____

Previous counseling/psychiatric history:_____
_____
_____

Presenting problem:_____
_____
_____
_____

Family history:_____
_____
_____

Spouse/partner:_____

Parents:_____

Siblings:_____

Children:_____

Other significant relationships:_____

Medical History:_____

RX or OTC medications_____

Alcohol or Drug use_____

Education level_____

Employment:_____