Restoration Counseling Services
Client Intake Form

Name: _____ Today's Date: _____

Address:

_____

Street & Number City State Zip

Telephone(s): Home_____Work_____ Cell_____

OK to leave a message at # _____

e-mail address: _____

Is it ok to send an e-mail to this address? Yes _____ No _____

Birth Date: _____ Gender: ____M ____F Race: _____

Occupation: _____ Years employed: _____

Marital Status: _____

Medical conditions: _____

_____

Medications (indicate name, reason and dosage): _____

_____

Doctor responsible for your care_____

Previous therapy (with whom? For what? How long?)

_____

_____

Person to contact in case of emergency:

_____

Name Phone Relationship

How were you referred?:

_____

Brief description of your reason for seeking help:

_____

_____

_____

Signature of client: _____ Date: _____