

# Initial Therapy Intake Form

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Address: \_\_\_\_\_

Parish: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Name of Spouse/Partner: \_\_\_\_\_

How Long Have Both of You Been Together? \_\_\_\_\_

Do you attend Church?  Yes  No Name of Church: \_\_\_\_\_

Do you have children?  Yes  No Ages: \_\_\_\_\_

*There are times when prior medical and psychological records maybe requested.*

*Please make sure that all information given below is correct.*

Do You Smoke?  Yes  No How Much? \_\_\_\_\_

Do You Drink?  Yes  No How Much? \_\_\_\_\_

Are you on medication? \_\_\_\_\_ If yes, what kind? \_\_\_\_\_

How often? \_\_\_\_\_

Any Previous Therapy/Counseling? \_\_\_\_\_ If Yes, Describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

When and Number of Sessions: \_\_\_\_\_

Type of Therapy/Counseling: \_\_\_\_\_

How were you referred to Dr. Peets? \_\_\_\_\_

Briefly describe the reason why you are now seeking counseling service, and how we can help:

\_\_\_\_\_  
\_\_\_\_\_  
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What do you wish to achieve with counseling?

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What problems are occurring that you will like to be addressed?

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What would success look like for you?

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