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: ____________________________

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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?

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

What would success look like for you?