CIRCLE OF LOVE COUNSELING CENTER

CLIENT INTAKE FORM

(Please Print)

Today's date:			Primary Care Physician:			
PATIENT INFORMATION						
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	Occupation:	Email:	Birth date: / /	Age:	Sex: ❑ M ❑ 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): ❑ Dr. _____ ❑ Church ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Internet ❑ 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? ❑ No ❑ Yes Please Explain:						
Please indicate type of counseling you would like to receive: ❑ Individual ❑ Family ❑ Couples ❑ Pre-marital ❑ Crisis ❑ Grief & Loss ❑ Parenting Teen ❑ Depression ❑ Anxiety ❑ Spiritual ❑ 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? ❑ Yes ❑ No Do you have any suicidal thoughts? ❑ Yes ❑ No						

IN CASE OF EMERGENCY			
In case of medical emergency who can I call:	Relationship to patient:	Home/Cell phone: ( )	Work phone: ( )
The above information is true to the best of my knowledge.			
Patient/Guardian signature:		Date:	