Transitions Counseling Intake Form

Date _____

Client Name: _____ **Race (optional)** _____

Client Name: _____ **Race (optional)** _____

Responsible Party (if a minor) _____

Birth Date _____ **Age** _____ **Gender** _____

Others participating in counseling: _____

_____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone ( ) _____ - _____ **May we leave a message?** ____Yes ____NO

Cell / Other Phone ( ) _____ - _____ **May we leave a message?** ____Yes ____NO

Email: _____ **May we email you** ___Yes ___No

***Please note: Email correspondence is not considered to be a confidential medium of communication.**

How did you learn of our services _____

Were you referred by a psychologist or psychiatrist? _____Yes ____No

If Yes, Who _____

Would you like us to contact your Doctor to consult about your therapy ____Yes ____No

Doctors Address and phone number _____

In case of emergency, who should be contacted? _____

Emergency contact number _____ **Relationship to You** _____