Hope Counseling, Inc.

INTAKE FORM

PERSONAL DATA

Name(s): _____ Maiden Name_____ DOB_____

Address _____ Zip _____

SS # __xxxxxxxxxxxxxxxxxxxxxxxxx_____ Phone # _____ Marital Status _____ Sex: ❒ M ❒ F

Who referred you: _____Phone # ___xxxxxxxxxx____ Patient's Employer _____

Employer's Address _____ Employer's Phone # _____

Emergency Contact _____ Phone # _____

FAMILY MEMBERS

Name	Age	Occupation	Relation to Patient

MARITAL HISTORY

Name of spouse	Began	Ended	How ended	# of children

EDUCATION

Name of School	City, State	Highest grade completed

MILITARY RECORD

Branch of service	Position	Type of discharge	Date of discharge

MEDICAL HISTORY

Hospitalization	Reason	Date

Major Illnesses, ailments, disabilities, etc:		
Allergies:		

Medications	Dosage	Prescribing doctor	Reason

PSYCHIATRIC HISTORY

Professional seen	Start Date	End Date	Reason seen

PROBLEM DESCRIPTION

In your words, briefly describe the problem for which you are seeking help:

MISC. INFORMATION

List any additional information that you feel may be important or helpful: