Connect Four Counseling, LLC
Intake Form

CLIENT INFORMATION

Please Print Clearly **THIS SHEET MUST BE FILLED IN COMPLETELY**

Date______________ Client's Social Security #__________________________________Email: ___________________

Client's First Name____ Last Name_____________________MI

Address____ City_____________________ State_______ Zip_________

Telephone (Home)____ (Work/Cell)_______________________________

Birthdate_____/_____/______ Age_______ Gender __F __M Race______________________________

Name of Spouse/Guardian____Phone_________________

Address____ City_____________________ State_______ Zip_________

Person Responsible for Payment____ Soc. Sec. #______________

Signature of Person Responsible for Payment **X**____________________________________ (Must be signed for services to begin)

Emergency Information

In case of emergency, contact:

Name (1) ________________________________ Relationship_____________ Phone_____________Work_________

Address____ City_____________________ State_______ Zip_________

Name (2) ________________________________ Relationship_____________ Phone_____________Work_________

Address____ City_____________________ State_______ Zip_________

Physician____ Phone__________________________

Address_________________________________ City___________________ State_______ Zip________________

Psychiatrist____ Phone__________________________

Address_________________________________ City___________________ State_______ Zip________________

Other Physicians____ Phone__________________________

Current Medications____

Allergies____

Employment Information (If client is a child, use parent's employment)

Client/Guardian: Place____ Phone____________________Hrs_________

Spouse: Place____ Phone_____________Hrs__________

What brings you to therapy? ____

____

Spiritual/Religious and Ethnic Identification:

How important are spiritual concerns in your life? ____

Would you like **spiritual/religious** beliefs incorporated into your sessions? ___ Yes ___ No

Which (if any) church are you involved with? ____

Ethnicity/National Origin: ____

What do you hope to gain from therapy?____

____

Why are you seeking help at this time?

____

____

What is your biggest strength and what is your biggest weakness? ______________________________________

Referral Source

How did you hear of our practice (or from whom)?____

Address________________________________ City___________________ State_______ Zip___________

Phone____ Relationship to referral source__________________________