Form 1

INTERPROFESSIONAL CENTER FOR COUNSELING & LEGAL SERVICES:
COUNSELING SERVICES

CLIENT INFORMATION INTAKE FORM

Name: _____ Date: _____

Birthdate: _____ Age: _____ Gender: _____ Ethnicity:_____

Address: _____
Street Apt. / Suite

_____
City State Zip

Home Phone: _____ May we leave a message? Y___ N___

Alternate Phone: _____ May we leave a message? Y___ N___

E-mail address: _____

Marital Status:_____ Education:(highest level completed) _____

Are you currently insured? _____ No _____ Yes

If Minor:

Parent(s) Name(s): _____

Home Phone: _____ Alternate Phone: _____

Address (if different):

_____
Street Apt. / Suite

_____
City State Zip

Primary Language_____

Second Language_____ **Requires Interpreter** ☐

Emergency Contact Information

Please list the name, address, and telephone number of someone that we may contact in case of an emergency.

Name: _____ Phone: _____

Relationship to you: _____

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Provider Information

Primary Care Clinic: _____ Phone: _____

Provider's Name: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Primary Therapist: _____ Phone: _____

Current Medications

Medication	Dose	Frequency	Condition

If you need additional room, please use another sheet of paper

Please describe any ongoing medical conditions you have:

_____

_____

_____

_____