

PEACE OF MIND COUNSELING, LLC
Client Intake Form

TODAY'S DATE _____

CLIENT NAME _____

RESPONSIBLE PERSON
NAME _____

BIRTHDATE _____

RELATIONSHIP TO CLIENT _____

ADDRESS _____

ADDRESS _____

CITY _____ STATE _____

CITY _____ STATE _____

ZIP _____ County of Residence _____

ZIP _____ County of Residence _____

SEX: Male Female (circle one)

SOCIAL SECURITY # _____

SOCIAL SECURITY # _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

At which phone # is it okay for us to leave a message? Home ___ Cell ___ Work ___

May we contact you by E-Mail? Yes No If yes, Email Address: _____

*We will only use your email for correspondence directly related to your care here at Peace of Mind Counseling.
All efforts will be made not to include any personal or identifying information in email correspondence.*

CLIENT MARITAL STATUS: SINGLE MARRIED DIVORCED
(Circle one) SEPARATED DOMESTIC PARTNER WIDOW/ER

EMPLOYED: FULL TIME PART TIME SHELTERED EMPLOYMENT RETIRED
(Circle one) HOMEMAKER UNEMPLOYED STUDENT

EMPLOYER: _____

How did you hear about our services? Online Friend/Family Phone book Newspaper
Other _____ Referred by _____

EMERGENCY CONTACT:

Name _____ Relationship to client _____

Phone _____ Do we have permission to call this person if we feel client is experiencing an emergency situation? Y N

CLIENT'S CURRENT MEDICATIONS: _____

ALLERGIES or serious medical conditions? (List) _____

PHYSICIAN (Name and clinic) _____

Do we have permission to contact client's physician? Yes No

Staff only: ROI Signed Y N

... Continued on other side...