

CLIENT INFORMATION

Last Name

First Name

Date of Birth

Home Address

City

State

Zip Code

Telephone Numbers: _____

Home

Cell

Work

Preferred Contact Number Home Cell Work

May we leave a message at: Home Yes No Cell Yes No Work Yes No

Email Address*

Occupation

Employer's Name

Partner/Spouse Last Name

Partner/Spouse First Name

Date of Birth

Home Address

City

State

Zip Code

Telephone Numbers: _____

Home

Cell

Work

Preferred Contact Number Home Cell Work

May we leave a message at: Home Yes No Cell Yes No Work Yes No

Email Address*

Occupation

Employer's Name

*PLEASE NOTE: We will not share your email address with anyone not affiliated with Intentional Living.

Your Current Relational Status: Never married Married Divorced Separated Engaged Dating
 Widowed For how long? _____

Name(s) of Child/Children	Age	Living at home?
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you previously worked with or are you currently working with (check one) another therapist?

If so, what is the name of the therapist: _____

When was the last time you saw this therapist? _____

Approximately how long did this therapeutic relationship last? _____

Has your spouse/partner previously worked with or is s/he currently working with (check one) another therapist?

If so, what is the name of the therapist: _____

When was the last time s/he saw this therapist? _____

Approximately how long did this therapeutic relationship last? _____

What are the reasons for you considering therapy at this time? _____

Please list all of the prescribed medications you are currently taking. Include those of your spouse/partner if s/he will be attending therapy with you.

Client (check one)	Medication	Dosage	Prescribing Physician
<input type="checkbox"/> Self	_____	_____	_____
<input type="checkbox"/> Spouse/Partner	_____	_____	_____
<input type="checkbox"/> Self	_____	_____	_____
<input type="checkbox"/> Spouse/Partner	_____	_____	_____
<input type="checkbox"/> Self	_____	_____	_____
<input type="checkbox"/> Spouse/Partner	_____	_____	_____

Are you and/or your spouse/partner currently being treated by a physician for any medical conditions? If so, please provide a brief description. _____

_____.

Has anyone in your or your spouse/partner's immediate or extended family ever been treated or hospitalized for substance abuse, addictive or compulsive disorders, or any other psychiatric conditions? If so, please provide a brief description. _____

_____.

Who, other than your spouse/partner, should be notified in case of an emergency?

Last Name

First Name

Phone #

Street Address

City

State

Zip Code

Relationship: _____

How did you learn about Intentional Living?

Referral from friend/family Referral from physician/therapist Phonebook Internet

Other _____

May we send a note of gratitude to the person who referred you? Yes No

May we include your name in the note? Yes No

I hereby attest that the information provided above is current and accurate to the best of my knowledge.

Date

Client Signature

Please print your name

Client Signature

Please print your name