



SHARON COUNSELING CENTER

Intake Form

INTAKE DATE _____
HOME PHONE _____
WORK PHONE _____
CELL PHONE _____
EMAIL ADDRESS _____

NAME _____ PREFER TO BE CALLED _____

ADDRESS _____ TOWN _____

STATE _____ ZIP _____ SOCIAL SECURITY # _____

BIRTHDATE _____ AGE _____ SEX _____ MARITAL STATUS _____

DATE OF MARRIAGE _____ DIVORCED/SEPARATED _____

EDUCATION _____ OCCUPATION _____

NAME AND ADDRESS OF WORK _____

ETHNICITY _____ RELIGIOUS BACKGROUND _____

CHURCH AFFILIATION _____

FAMILY PHYSICIAN _____ TELEPHONE _____

DATE OF LAST PHYSICAL EXAM _____

HEALTH PROBLEMS: PAST _____

PRESENT _____

CURRENT MEDICATION _____

IF MARRIED, INFORMATION ON YOUR SPOUSE

FULL NAME _____ AGE _____ BIRTHDATE _____

ADDRESS (IF DIFFERENT) _____

EDUCATION _____ OCCUPATION _____

PLACE OF WORK _____ PHONE _____

ETHNICITY _____ RELIGIOUS BACKGROUND _____

EMERGENCY CONTACT _____ PHONE _____

MEDICAL INSURANCE _____ POLICY # _____

ANY PREVIOUS COUNSELING IN PAST _____ WHERE _____

WHEN _____ WAS IT POSITIVE OR NEGATIVE EXPERIENCE _____

HOW DID YOU HEAR ABOUT ME _____

WHAT ARE YOUR REASONS FOR SEEKING COUNSELING AT THIS TIME?

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