CLIENT Intake Form

Tracy Wise, LPC **Today's Date:**_____

Name_____ Age_____ Occupation_____

Street Address_____

City, State, Zip_____

Home Phone_____ Work Phone_____

E-mail address_____

Married__ Divorced__ Single__ Names of other family members:_____

Referred by_____ Phone_____

Primary Care_____ Phone_____

Additional Care_____ Phone_____

Most Prominent Problems Now: **For How Long?**

_____
_____
_____
_____
_____
_____
_____

How were you before these problems occurred (if relevant)?

_____
_____
_____
_____

(Please fill out the reverse side also…)

Previous symptoms throughout your entire life:

_____
_____
_____
_____
_____

List any history of accidents, including falls, auto accidents or sports injuries including any concussions: **When did it occur?**

1)_____
2)_____
3)_____
4)_____
5)_____
6)_____
7)_____
8)_____
9)_____
10)_____

Current medications, reasons for taking them, and their effects on you:

_____
_____
_____
_____
_____

How much time and money have you spent on your primary problem?

_____
_____
_____

How will you know you are done?

(Please state 5 specific areas in which you can measure your healing, or reduction of the symptoms that brought you here for treatment.)

1)_____
2)_____
3)_____
4)_____
5)_____