

Directive Counseling Intake Form

Last Name: _____ First Name: _____
Address: _____ City: _____ Zip: _____
Birthdate: _____ Age: _____
Home Phone: _____ Cell Phone: _____
E-Mail Address: _____
Emergency Contact: _____ Contact's Phone: _____
Occupation: _____

Please state primary reason for you visit: _____

Ethnic Background

____ American Indian/Alaskan Native
____ Asian
____ African American
____ Hispanic
____ Pacific Islander/Native Hawaiian
____ Caucasian
____ Other: _____
____ Prefer Not to Disclose

Relationship Status

____ Committed Partnership
____ Divorced
____ Married
____ Separated
____ Single
____ Widowed
____ Other: _____

Responsible for Dependents

____ Yes ____ No

Education

____ High School - No Diploma
____ High School Diploma or GED
____ Trade Certificate
____ College - No Degree
____ Associate's Degree
____ Bachelor's Degree
____ Master's Degree
____ Professional Degree
____ Ph.D.
____ Other: _____

Mental Health History (Diagnosis)

Medication History (If applicable)

Medical History