

Couple & Family Intake Form

CLIENT INFORMATION

Please provide the name and information regarding each client who will be an active part of the couple or family therapy process.

Client 1			
First	Middle	Last	
		Male/Female (Circ	le one)
Date of Birth		Age	,
Social Security Number			
Address: Street			
City		State	Zip
Primary Phone Number		Ok to Leave a Message? Yes	No
		Ok to Leave a Message? Yes	No
Secondary Phone Number			
School OR Employer			Grade, if applicable
Client 2			
First	Middle	Last	
Date of Birth		Male/Female (Circle one) Age	
	,	.90	
Social Security Number			
Address: Street			

City	State	Zip	
Primary Phone Number	Ok to Leave a Message?	Yes No	
Trimally trions reambor	Ok to Legye a Magazaga?	Voc. No.	
Secondary Phone Number	Ok to Leave a Message?	res No	
School OR Employer		Grade, if a	 applicable
Client 3			
First	Middle	Last	
	Male/Female	(Circle one)	
Date of Birth	Age		
Social Security Number			
Address: Street			
City	State	Zip	
	Ok to Leave a Message?	Yes No	
Primary Phone Number			
Secondary Phone Number	Ok to Leave a Message?	Yes No	
School OR Employer		Grade, if a	 applicable
Client 4			
First	Middle	Last	
Date of Birth	Male/Female Age	Age Male/Female (Circle one)	
Social Security Number			
Address: Street			

City	 State		Zip
Primary Phone Number	Ok to Leave	e a Message? Yes	No
Secondary Phone Number	Ok to Leave	e a Message? Yes	No
School OR Employer			Grade, if applicable
Client 5			
First	Middle	Last	
		Male/Female (Circ	cle one)
Date of Birth	Age	·	,
Social Security Number			
Address: Street			
City	State		Zip
	Ok to Leave	e a Message? Yes	No
Primary Phone Number			
	Ok to Leave	e a Message? Yes	No
Secondary Phone Number			
School OR Employer			Grade, if applicable

Provide additional copies if more than 5 clients will be part of the couple or family therapy process.

Emergency Contact Name	Emergency Contact Phone Number
How did you learn about Encompass Mental Health?: _	
INSURANCE	
Health Insurance Provider	Health Insurance ID/Group Number
Name of Policy Holder	Policy Holder's Date of Birth
Policy Holder's SSN	Relationship to Client
BACKGROUND	
Previous Counseling Experience:	
Briefly explain the reason for seeking counseling:	
Are there any medical illnesses or unusual experiences No	s that the therapist should be aware of?
Please explain:	