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 (Circle one)
Date of Birth Age

_____-____-_____
Social Security Number

_____
Address: Street

_____ _____ _____
City State Zip

_____ Ok to Leave a Message? Yes No
Primary Phone Number

_____ Ok to Leave a Message? Yes No
Secondary Phone Number

_____ _____
School OR Employer Grade, if applicable

Client 2

_____
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

_____ Ok to Leave a Message? Yes No
Secondary Phone Number

_____ _____
School OR Employer Grade, if 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

_____ Ok to Leave a Message? Yes No
Secondary Phone Number

_____ _____
School OR Employer Grade, if applicable

Client 4

_____
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

_____ Ok to Leave a Message? Yes No
Secondary Phone Number

_____ _____
School OR Employer Grade, if applicable

Client 5

_____
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

_____ Ok to Leave 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 that the therapist should be aware of?
No

Please explain: _____

_____

_____

_____

_____

_____

_____