

CLIENT INTAKE DATA SHEET

MARK HOAGLAND, MA

COUNSELING SERVICES

LAST NAME _____ HOME PHONE _____

FIRST NAME _____ WORK PHONE _____

ADDRESS _____ CELL PHONE _____

CITY, STATE, ZIP _____

EMAIL _____ SSN _____

DOB: ___/___/___ AGE _____ SEX: M F REFERRED BY _____

EMPLOYER/SCHOOL _____ OCCUPATION _____

EDUCATION: K 1 2 3 4 5 6 7 8 9 10 11 12 - GED COLLEGE 1 2 3 4 5 6 7 8+

CURRENT PHYSICIAN _____ PHONE _____

SIGNIFICANT MEDICAL HISTORY _____

CURRENT MEDICATIONS _____

COUNSELING HISTORY (COUNSELORS) _____

PLEASE DESCRIBE BRIEFLY WHY YOU ARE SEEKING COUNSELING AND YOUR HOPES ABOUT WHAT YOU WOULD LIKE TO ACCOMPLISH THROUGH THERAPY:

IN CASE OF EMERGENCY PLEASE NOTIFY:

NAME(S) _____ RELATIONSHIP _____

ADDRESS _____

CONTACT PHONES _____

CLIENT SIGNATURE: _____ DATE: _____

MarkHoagland\Intake, 10/17/05