

# ACTSolutions

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## CLIENT INTAKE FORM

Name: \_\_\_\_\_ Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_  
SS#: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Street Apt.# City State Zip

Marital Status:  Never married  Married  Widowed  Divorce  Separated  
If married, how long? \_\_\_\_\_ Wedding Date: \_\_\_\_\_  
If divorced, how long? \_\_\_\_\_ If 2<sup>nd</sup> or 3<sup>rd</sup> (etc.) marriage, please indicate \_\_\_\_\_  
Religious background (denomination): \_\_\_\_\_  
Place of Employment: \_\_\_\_\_ Position title: \_\_\_\_\_  
Hours worked per week: \_\_\_\_\_ Salary (needed if choosing sliding scale): \_\_\_\_\_  
Spouse Name (if applicable): \_\_\_\_\_ Place of Employment: \_\_\_\_\_  
Name of children living in your home:

Name	gender	DOB	Age	Sch/Occup	Marital Status
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

List any children not living in your home:

Name	gender	DOB	Age	Sch/Occup	Marital Status
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Have you (or your spouse) ever been involved in therapy or any other type of counseling?  yes  
 no If yes, When: \_\_\_\_\_ Where: \_\_\_\_\_  
Reasons: \_\_\_\_\_

Reasons for seeking counseling at this time: \_\_\_\_\_  
\_\_\_\_\_

Were you referred to this office?  yes  no If yes, by whom? \_\_\_\_\_

Are you in treatment with another counselor at this time?  yes  no If yes, with whom?  
\_\_\_\_\_ at \_\_\_\_\_. How long? \_\_\_\_\_

List any medications you are currently taking: \_\_\_\_\_  
\_\_\_\_\_ Physician who prescribed meds: \_\_\_\_\_

Person to contact in case of an emergency: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Address: \_\_\_\_\_

What do you expect, hope to gain from therapy? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.*

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_