



ELBOW TREE

Clinical Intake and Personal Data

Name(s): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Other: _____

Email: _____ Website: _____

Please CIRCLE any addresses, phone numbers or e-mails that you DO NOT want me using to reach you OR leaving a message. I do not want to compromise your confidentiality or create an uncomfortable situation.

Are you Married? _____ For How Long? _____

Previous Marriages? (Him) _____ How Many? _____ (Her) _____ How Many? _____

Are your parents divorced? (Him): _____ How old were you? _____ (Her): _____ How old were you _____

Please give the following info for each person that currently lives in your home, including yourself:

<u>Name</u>	<u>Age</u>	<u>Relationship to Self</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you currently taking any prescription psychiatric medications? _____

<u>Dr./Drug</u>	<u>Reason</u>	<u>How Long</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any current or expected legal involvement? _____ If yes, please explain: _____

Are you currently under an order of protection? _____ If yes, please explain: _____

Who may we contact in the event of an emergency? Please mark your initials to give us permission to do this. _____

Name: _____ Relationship: _____

Address: _____ Phone: _____

Do you currently attend any church? Which one? _____

What is your occupation? (Him): _____ (Her): _____

Have you ever been to see a therapist before? _____

Was it helpful? _____

How did you hear about Elbow Tree Christian Counseling? _____

May we thank them for referring you? _____

What brings you to therapy today? _____

Do you have any other special circumstances or information that would be helpful for me to know? _____

***Are you allergic to dogs or do you have an aversion to them? _____

From time to time, Elbow Tree staff will bring their dogs to the office with them.

Credit Card Information:

Card Type _____ Card Number _____

Expiration _____ / _____ CV Code _____ Billing Zip Code _____

I authorize Hayne Steen, LMHC to bill my credit card after each client session.

Signature _____ Printed Name _____