Strategic Solutions

Family, Couple & Individual Therapy

Intake Form

All Family Members:

Name _____ Age _____ DOB _____ Occupation _____
Name _____ Age _____ DOB _____ Occupation _____
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Name _____ Age _____ DOB _____ Occupation _____
Name _____ Age _____ DOB _____ Occupation _____

Address: _____

Phone Numbers: Cell _____ Other: _____ _____

What changes do you hope to achieve

_____
_____
_____
_____
_____

In single parent and/or remarried families, what is the custody arrangement

Single _____ Joint _____

According to the custody agreement, is the other custodial parent's consent to counseling required?

Yes _____ No _____

If yes, has the other parent agreed to counseling

Yes _____ No _____

Other parent's address _____ Phone _____

Pending legal issues _____

Prior therapy _____

Current prescription medications _____

Medical issues/last physical _____

Name of Physician _____

Additional Comments

_____
_____
_____