Jacksonville Counseling Services, LLC
13500 Sutton Park Dr. S, Suite 802
glawrencecounseling@gmail.com
973-362-6318

Client Intake Form
The information requested in this form will be kept confidential and will help your therapist assist you. Please fill out the form as completely as you can.

Name (s): _____ Date: _____

Address: _____ City/Zip: _____

Main Contact Phone: _____ Additional Phone: _____

Email Address: _____Date of Birth: _____

Occupation: _____

Marital Status: _____ Name of spouse/partner: _____

Children/Spouse's children (names and ages): _____

_____

Referred By: _____

Contact Person in Case of Emergency: _____

Emergency Contact Phone: _____

Who is your Primary Care Physician? _____

Current Medications: _____

Have you (check all that apply):	If yes, please explain
___ Seen a counselor/therapist/psychiatrist	_____
___ Been on medication for emotional reasons	_____
___ Been hospitalized for psychiatric reasons	_____
___ Been treated for drug/alcohol problems	_____

Problem Definition

What is your reason for seeking help now? _____

_____

_____

_____

_____

Are any of the following conditions a problem to you at this time? (Check the ones that apply)

__ Anxiety
__ Grief
__ Depression
__ Irrational Fears
__ Nervousness
__ Loneliness
__ Anger
__ Marriage Problems
__ Sexual concerns
__ Loss of work/job
__ Self esteem
__ Stress
__ Substance Abuse
__ Chronic Fear
__ Guilt Feelings
__ Suicidal Feelings
__ Loss of Hope
__ Rage
__ Relationship with parents
__ Relationship with children
__ Loss of meaning of life
__ Loss of faith in God
__ Conflicts at work
__ Thoughts of harming self or others
_____
_____
_____
_____

Do you have a religious preference that you'd like incorporated into your treatment? If yes, please explain.

_____

_____

Please sign and date this document stating that the information you have written on this form is accurate to the best of your knowledge.

_____ _____

Client's Signature Date

_____ _____

Parent of minor client (under 18 yrs) Date