

COOKS COUNSELING
 'WHERE YOU CAN FIND HOPE AND HEALING'

INTAKE FORM

DATE: _____

Identified Client Information

NAME: _____	(Circle one below) MARITAL STATUS: _____
ADDRESS: _____ CITY: _____ TX ZIP: _____ Email Address: _____	Single Married Divorced Widowed
DOB: _____ (circle) MALE/FEMALE	
How would you like to be reminded for appointments? Circle- Text, cell phone call, home call, email, or no reminder	
HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____	CAN WE LEAVE MSG. YES NO YES NO YES NO
<u>Cell phone service provider is whom?</u> NAME AND PHONE NUMBER OF PCP-	

EMPLOYER _____	Highest Grade Completed: _____
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Past or current:	Current Medications	Dosages
Alcohol use: x per week		
Drug use: x per Week Type:		
Significant Health Issues:		

Insurance Subscriber Information-

Name:	Ins. Carrier:	
SS#:	Ins. Phone No.	
DOB:	Ins. ID No.	
Employer:	Group No.	
EAP Provider:	Authorization No.	No. of sessions approved:

ADDITIONAL HOUSEHOLD MEMBERS	RELATIONSHIP TO CLIENT	Age	Will participate in Sessions?

Who would I contact in case of an emergency? _____

Relationship to you- _____ Phone # _____

Prior counseling? Y N If yes, with whom and when? _____

What would you identify as your main complaint or issue? _____

If Identified client is under 18 years old, please add parent(s) names and phone contact information.

Parent _____ Contact information _____

Parent _____ Contact information _____