Kimberly Simpson, LPC, MHSP (615) 323.2207

Confidential Intake Form

_____
Today's Date

Personal Information

Name_____Phone_____Alternate #_____

Address_____
City state zip

Date of Birth_____ Age_____

Family Status _____ If married, how long? _____

Occupation_____Employer_____

Do you identify with any religious organization? _____ if so, where?_____
How would you rate your overall health?_____

Are you taking any medications currently? If so, please list _____

_____

When were you last examined by a physician? _____

Name your Primary Physician_____ Phone _____

Address_____

Have you ever received counseling or been hospitalized for mental health/emotional reasons? If so, please list below:

Name/Address	Dates of Treatment	Reason for termination
Name/Address	Dates of Treatment	Reason for termination
Name/Address	Dates of Treatment	Reason for termination

Spouse Info (if applicable)

_____
Name Date of Birth

Phone_____
Work Cell

_____
Occupation Employer

Children (if applicable)

_____
Name Age

_____
Name Age

_____
Name Age

Referral Information:

Referred by_____ Phone _____

Briefly describe your reason for seeking counseling: _____

_____

Are there any other concerns you have currently? _____

_____

Person to be contacted in case of emergency:

_____ _____
Name/Relationship to you Phone Number

_____[1]
Client Signature ***Parent Signature*** *(if applicable)* ***Date***

[1] March 2009