# Intake Form

LIFE STRATEGY CONSULTANTS, LLC

Professional Counseling, Consulting & Educational Services

Client Name _____ Date of Birth ____/____/____

Address _____

City _____ State _____ Zip _____

Mobile Phone (_____)_____ ❑ No Messages ❑ Voice Msgs OK ❑Text Msgs OK

Home Phone (_____)_____ ❑ No Messages ❑ Voice Msgs OK

Work Phone (_____)_____ ❑ No Messages ❑ Voice Msgs OK

Email Address _____ ❑ **Please email me appointment reminders**

Gender: ❑Male ❑Female Marital Status: ❑Married ❑Single ❑Other

Employment Status: ❑Employed ❑Full-time Student ❑Part-time Student ❑Unemployed/other

Educations: Please circle the number that most closely represents your level of education (years)

Primary/High School **6 7 8 9 10 11 12** College/Trade School **13 14 15 16** Graduate School **13 14 15 16+**

Ethnicity: ❑Caucasian ❑African-American ❑Hispanic ❑Native America ❑Asian ❑Other_____

Religious Affiliation: ❑None ❑Catholic ❑Protestant ❑Jewish ❑Other_____

How important is your religion/faith in your life?

Not important 1 2 3 4 5 6 7 8 9 10 Very Important

List your family members

| NAME | AGE | GENDER | RELATIONSHIP |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Briefly state your reason for seeking counseling

_____

_____

_____

_____

_____

_____

_____

_____

List any current medication (attach separate paper if additional space is required)

| NAME | DOSAGE | PURPOSE | PHYSICIAN |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Have you previously received any mental health, substance abuse, or counseling services? ❑ NO ❑ YES:

| SERVICE | PROVIDER | DATES | REASON |
|---|---|---|---|
| Psychotherapy/Counseling | | | |
| Medication Management | | | |
| Intensive Outpatient (IOP) | | | |
| Inpatient Hospitalization | | | |
| Substance Abuse/Addictions | | | |
| Other_____ | | | |

How did you hear about Life Strategy Consultants, LLC

❑ Referred by a medical provider/insurance company _____

❑ Referred by church/pastor _____

❑ Internet search

❑Website

❑PsychologyToday.com

❑ Word of mouth/Family

❑ Other _____

**EMERGENCY CONTACT**

Contact Name _____

Address _____

City _____ State _____ Zip _____

Phone (_____)_____ Relationship _____

Email Address: _____

**PRIMARY CARE PHYSICIAN/FAMILY DOCTOR**

Medical Practice's Name _____

Physician's Name _____

Address _____

City _____ State _____ Zip _____

Phone (_____)_____ Fax (_____)_____

***May we contact your physician and receive medical records for continuity of care?*** ❑ Yes ❑ No

**MEDICATION MANAGEMENT PRESCRIBER**

Medical Practice's Name _____

Prescriber's Name _____

Address _____

City _____ State _____ Zip _____

Phone (_____)_____ Fax (_____)_____

***May we contact your prescriber and receive medical records for continuity of care?*** ❑ Yes ❑ No

Client Signature _____ Date _____

Signature of Witness _____ Date _____