Angela Osborne MA, LMFT
Wish-Breathe-Believe Counseling Services
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CLIENT INTAKE FORM

Name: _____ Date of Birth: _____ Gender: □Male □Female

Education completed: _____ Religious/Spiritual Affiliation: _____

Occupation: _____ Employer: _____

Home Address: _____ City:_____ Zip: _____

Home Phone #: _____□ Work Phone #: _____□

Cell Phone #: _____□ Email: _____□

Check □ if it is okay for me to leave a message at this number/email

Please List Other Family Members and/or Significant Others

Name	Gender	Age	In Home?	Relationship to First Person Listed Above

Please List Any Medication(s)You or Members of your Family are Currently Taking

_____

_____

Please List Any Medical Concerns that Affect You and/or Family Members:

_____

_____

Substance Use (tobacco, alcohol, illegal drugs, etc) by You or Family Members (Type, Frequency, Amount)

Family History of Emotional or Social Problems (e.g., depression, anxiety, interpersonal conflicts)

Family History of Physical, Sexual, and/or Emotional Abuse (check all that apply)

Physical _____ Sexual _____ Emotional _____ None_____

Previous Counseling/Therapy Experiences (Who did you see, when, why?):

What brought you in today?

What are your goals for therapy?

Please list the areas of your life that you would like to change or need improvement:

Please list your three greatest strengths:

Signature of person filling out form: _____ Date: _____