

Angela Osborne MA, LMFT
 Wish-Breathe-Believe Counseling Services
 3224 6th Avenue
 Tacoma, WA 98406
 (253) 878-0365
 www.wishbreathebelieve.com



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: _____