SUSAN GOEDDE, LCSW **CLIENT INTAKE FORM**

Date: _____

Name:_____ Date of Birth: _____

Address: _____ Phone: w:_____

_____ h: _____

_____ Social Security #_____

Referral source ("how did you get my name"): _____

_____

Employer/School: _____

Occupation: _____

Primary Insurance: _____Name of Insured:_____

Secondary Insur.: _____Name of Insured: _____

Current reason for seeking counseling: _____

_____

_____

_____

Goals for therapy: _____

_____

History/current medical problems: _____

_____

_____

Current Medications: _____

_____

Name/phone # of primary care physician: _____

_____

Experience with therapy: (when, how long, with whom?) _____

_____

Describe current family or living situation: _____

_____

Emergency contact:_____ Phone: _____

Rev. 4/19/02