Jerry Franklin Counseling

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Client Information

Please fill out this form completely and accurately. Information on this form is kept strictly confidential. Your therapist will review this information with you if he or she has any questions or may ask for additional background information during the therapy session. If any of the information requested does not apply to you, please write "N/A" in the space provided. If you have any questions about this form, please ask your counselor for assistance.

Client Information

The person's name listed as the "client" should be the person in whose name the person will be responsible for paying the fee for service and/or the person who will be the focus of therapy. If the client is a minor child, his or her name should be entered as the "client."

Person filling out this form _____ Date_____

Relation to client_____

Client's Name_____ DOB_____

Client Address_____ Client Phone: home_____

_____ work_____

City_____ State_____Zip_____ cell_____

Age____Gender_____ Email address: _____

Relationship Status (circle one): Single Married Separated/Divorced Coupled Minor Child

Client's Place of Employment or School /Grade_____

Client Medication

Please list all current prescription medications that have been prescribed to the client and over-the-counter medications that are being used by the client on a regular basis. If you require more space to write, please use the back of this form.

Medication Dose When Prescribed

_____

_____

_____

_____

Type of Counseling Desire (please circle one): Individual Marital Relationship

Family (problems w/ child) Family (other)

In case of emergency (contact person)_____

Phone: home_____ work_____ cell_____

Client Spouse/Partner Information

If applicable, please provide the following information about the client's spouse or partner. If the address of the spouse or partner is the same as the client, the address information is this section may be marked "same."

Spouse/Partner's Name_____

Address_____ Phone: home_____

_____ work_____

City_____State_____Zip_____ cell_____

Payment Information

Payment of fee or co-pay must be made at the time services are rendered. Checks and credit/debit cards are accepted. Otherwise, the client or his/her custodian is responsible for the full fee.

Name of Person Responsible for Payment_____ DOB_____

Address_____ State_____Zip_____

Phones: Home_____Work _____Cell _____ SSN _____ - _____ - _____

Method of Payment (please circle one): MC Visa Amex Discover Other: _____

Credit Card/Debit Card: _____ exp.____/_____ CCV:_____

General Information

Please answer the following questions in regard to the client and the client's family, as applicable.
Answer each question by circling "Yes" or "No."

Yes	No	May your counselor (and/or staff) leave messages at the telephone numbers you have provided on this intake form?
Yes	No	May your counselor (and/or staff) send written correspondence to the contact addresses you have provided on this intake form?
Yes	No	Is the client or any person involved in therapy a party to any ongoing civil or criminal litigation?
Yes	No	Is the client or any person involved in therapy under a court order?
Yes	No	Is the client or any person involved in therapy currently seeing another mental health professional?
Yes	No	Has the client (and spouse, in the case of marital therapy) had a routine physical in the last year?
Yes	No	Does the client (and spouse, in the case of marital therapy) have a primary care physician?
Yes	No	Has the client or client's custodian received family or mental health counseling of any kind in the past?

Counseling Process Information

Please review the following statements and place a check by the two (2) responses that most nearly apply to you, the client:

____ I am coming to counseling to work on personal/emotional issues.
____ I am coming to counseling to work on my relationship skills.
____ I am coming to counseling to learn how to adjust to a difficult or hurtful situation.
____ I am coming to counseling because I have suffered a serious loss.
____ I am coming to counseling to enhance and enrich my relationship with my mate.
____ I am coming to counseling to work on urgent problems in my marriage.
____ I am coming to counseling to make some minor but needed adjustments in my marriage.
____ I am coming to counseling to prepare myself for marriage or remarriage.
____ I am coming to counseling to improve my parenting skills or co-parenting with ex-spouse.
____ I am coming to counseling because I am concerned about the behavior/adjustment of a minor child.
____ I am coming to counseling because I am concerned about adult family relationships.

Custodial Parent(s) Information [Complete only if applicable.]

Please provide the following information if the client is a minor child or the focus of therapy is the behavior or well-being of a minor child. This portion of the intake form should be filled out by or on behalf of the adult(s) with whom the child lives and/or that have primary custodial responsibility for and manage the day-to-day welfare of the child who is the focus of therapy.

Name of Male Custodian_____

Relation to Child (circle one): Birth Father Adopted Father Stepfather Foster Father Other:

Age____ Phone: home_____work_____cell_____

Name of Female Custodian_____

Relation to Child (circle one): Birth Father Adopted Father Stepfather Foster Father Other:

Age____ Phone: home_____work_____cell_____

Custodian(s) Current Relationship Status (circle one): Married Coupled Single

Address of Custodial Parent(s)_____State____Zip_____

Siblings Living in Home with Child:

Name_____Gender_____Age____Name_____Gender_____Age____

Name_____Gender_____Age____Name_____Gender_____Age____

Name_____Gender_____Age____Name_____Gender_____Age____