Intake Forms

Counseling Services of Beaufort, LLC

Client Information

Client(s) Name: 1.)_____ Date: _____
2.)_____

Address:_____City:_____State: _____Zip:_____

1.) Age: _____ Birth Date: ____-____-____ Gender: _____
2.) Age: _____ Birth Date: ____-____-____ Gender: _____

1.) Phone Numbers: Work: _____ Home: _____ Cell_____
2.) Phone Numbers: Work: _____ Home: _____ Cell _____

Do I have your permission to call you at these numbers and identify myself and profession?

1.) Email address _____
2.) Email address _____

Client 1.)
Work: (please circle one) Yes No
Home: (please circle one) Yes No
Cell: (please circle one) Yes No

Client 2.)
Work: (please circle one) Yes No
Home: (please circle one) Yes No
Cell: (please circle one) Yes No

1.) Social Security Number: _____-_____- _____
2.) Social Security Number: _____-_____- _____

Marital Status: 1.)_____ Education Completed: 1.) _____
Marital Status: 2.)_____ Education Completed: 2.) _____

Occupation: 1.)_____Employer:1.)_____
Occupation:2.)_____Employer:2.)_____

Family Members:
Spouse: _____Age: _____ Years Married: _____

Parent / Guardian: _____

In case of emergency call _____ phone number_____

	Client # 1	Client # 2
Children:	_____ Age: ____	_____ Age: ____
	_____ Age: ____	_____ Age: ____
	_____ Age: ____	_____ Age: ____

Are you taking any medications? Yes No From Dr. _____

List Medications:_____
Family Physician: _____
Referred by: _____
Please Sign: 1._____
2._____