Inner Peace Counselors, PLLC

Client Intake Information

Client's Name _____ Gender: _____ Age ___

Spouse/Partner's Name _____ Age _____

Name of Parent or Guardian(s) if client is a minor _____

Address (Street): (City) (ZIP) _____

Phone Numbers/e-mail **(only include those that we have permission to call or leave a voice/email message)**:

Home _____ Work _____ Cell _____

e-mail _____ Marital Status _____ Date of Marriage _____

Guardian/Spouse Name (as appropriate) _____

Client Social Security # _____ Driver's License # _____

Date of Birth _____ Occupation _____ School Attended _____

How did you find out about Inner Peace Counselors, PLLC? _____

Religious Orientation _____ Church Affiliation _____

Family Members living at home

Name	Age	Birth-date	Relationship to client

Medical/Health Information:

In case of emergency, you may call _____ Phone # _____ Relationship _____

Personal Physician: _____ Phone # _____

Date of last physical: _____ Major illnesses/conditions _____

Previous Counseling: Yes ☐ No ☐ If yes, when _____ With whom _____

Medications you are currently taking?

_____ _____

Client/Guardian Signature Date