

# 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? Yes No

1.) Email address: \_\_\_\_\_  
2.) Email address \_\_\_\_\_

Client 1.)	Client 2.)
Work: (please circle one) Yes No	Work: (please circle one) Yes No
Home: (please circle one) Yes No	Home: (please circle one) Yes No
Cell (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. \_\_\_\_\_