Fairview Counseling of Chester County
Client Intake Form

Client Name: _____ _____ Preferred: _____
LAST FIRST

Client DOB: _____ Age:_____ Gender:_____

Address: _____
STREET CITY STATE ZIP

Phone: Home: _____ Leave a message? Yes/No

Cell: _____ Leave a message? Yes/No

Email address: _____ Occupation: _____

Employer/School: _____

- If client is a minor, please provide the name/address/phone of parent or guardian below:

Name:_____ Relationship to client:_____

Address: _____
STREET CITY STATE ZIP

Phone: Home: _____ Leave a message? Yes/No

Cell: _____ Leave a message? Yes/No

Name of financially responsible party: _____
Name Phone

Referred by: _____

Family Members:

Please list the name, ages and relations of each person living in the household

Name	Age	Relation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical History:

Have you experienced any major illnesses, operations, injuries or hospitalizations? Yes/No
If yes, please provide details below:

_____
_____
_____

Medication:
Please describe any medications that address mental health issues:

Name	Dosage	Prescriber
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please describe your reason for seeking counseling services:

_____
_____
_____
_____
_____

What do hope to accomplish in our work together:

_____
_____
_____
_____
_____

Have you received counseling/therapy previously? Yes/ No

If yes, when did it occur and with who? _____

Previous diagnoses_____