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INTAKE FORM

Date: _____

Last Name: _____ First Name: _____

Birthdate: _____ Age: _____

Address: _____ City/State/Zip: _____

How long at this address: _____

Home Phone: _____ Cell Phone: _____

OK to leave message? Yes No Number Preferred: Home Cell

Married Single Separated Divorced Widowed Committed Relationship

Spouse's Name: _____ Birthdate: _____ Age: _____

Date of current marriage: _____

Previous marriage(s) for husband? How many? _____ Duration of each: _____

for wife? How many? _____ Duration of each: _____

Names and ages of children: _____

Names and ages of present household members: _____

Are there any serious medical problems or physical disabilities in your immediate family (parents, siblings, children)?: _____

Last Grade completed/degree(s)? You: _____ Spouse: _____

Your employer: _____ Phone: _____

Occupation: _____

Spouse's employer: _____ Phone: _____

Occupation: _____

Nearest relative not living with you: _____ Phone: _____

Whom may we thank for referring you? _____

Address: _____ Phone: _____

Whom may we contact in case of an emergency who does not reside with you? _____

Phone: _____

Briefly, how would you describe the situation or problem that brings you here: _____

Are you taking any medications? If yes, what, how much, and with what results: _____

Role of religion and/or spirituality in your life:

a. In childhood: _____

b. As an adult: _____

Present interests, hobbies, and activities: _____

How is most of your free time occupied? _____

What actions, if any, have you taken toward finding a solution? _____

Have you or any other family member ever received prior counseling or treatment?

Yes No

If yes, whom and when? _____

What do you expect to accomplish from therapy, and how long do you expect therapy to last?

What is there about your present behavior that you would like to change? _____

I would like Christian principles incorporated into my therapy Yes No

If yes, does this include scripture? Yes No

If yes, does this include prayer? Yes No