CCG Collaborative Counseling Group

Client Intake Form

Date:_____
Name of Client/Family:_____ **Client's Date of Birth**_____
Address:_____
City:_____ State:_____ Zip:_____
Telephone Numbers:
Home:_____Cell:_____Work:_____
Email:_____ Emergency Contact:_____
Referral Source:_____

Household Composition: **Adults**

First Name	Last Name	Preferred Pronoun	DOB	Marital Status

Children	First Name	Last Name	DOB	Relationship	Preferred Pronoun	Primary Residence
1st						
2nd						
3rd						
4th						

If Joint Custody is shared with another parent of Guardian, please provide contact information:
Name:_____ Relationship to client:_____
Address:_____
Home Phone:_____ Work Phone:_____
Cell Phone:_____ Email:_____

Brief Description of the Presenting Problem:

_____
_____
_____
_____

1525 King's Highway East, Suite 206 Fairfield, CT 06824
www.collaborativect.com
(203) 220-6595

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Previous Treatment:

Inpatient: _____
Outpatient:_____

What problems do you wish to solve in counseling?

Have you sought help for this problem before?

Do you have any physical health concerns?

Please list all medications taken by the client:

Medication Name	Dosage	Prescriber

Court Involvement or DCF involvement? (If yes, please explain)

Marital Status_____ Highest Grade Completed: _____

Employer/School:_____ Race/Ethnicity:_____

Primary language at home:_____ Spiritual Preference:_____

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