

Dawn Wade, MA, ATR, CHT, LMFT

Licensed Marriage and Family Therapist
Certified Hypnotherapist Registered Art Therapist

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CLIENT INTAKE FORM

Date: _____

(#1)Client name: _____ (#2)Client name: _____

Single _____ Partnership _____ Married _____ Separated _____ Divorced _____ Other _____

Street Address: _____ City: _____ Zipcode: _____

Mailing Address: _____ City: _____ Zipcode: _____

(#1) Birthdate: _____ Age: _____ SSN: _____ Driver's License# _____

(#2) Birthdate: _____ Age: _____ SSN: _____ Driver's License# _____

(#1)Home
Ph# _____ Cell# _____ Work# _____ Email: _____

(#2)Home
Ph# _____ Cell# _____ Work# _____ Email: _____

(#1)Employer: _____ Occupation: _____

(#2)Employer: _____ Occupation: _____

Emergency Contact: _____ Ph# _____

Relationship with Emergency Contact: _____

(If it becomes necessary to contact this individual, only information required to keep you safe will be disclosed.)

| | | |
|-------------------------------------|--------------------|-----------------------------|
| My Therapist may call me at my home | _____ yes _____ no | Explanation if needed _____ |
| My Therapist may call me on my cell | _____ yes _____ no | _____ |
| My Therapist may call me at work | _____ yes _____ no | _____ |
| My Therapist may email me | _____ yes _____ no | _____ |
| My Therapist may text message me | _____ yes _____ no | _____ |

Family Physician: _____ Ph# _____

Please list medications currently taking (including supplements):

How were you referred you to me? _____ Are you being court-ordered for therapy? _____ yes _____ no
Previous Counseling? _____ yes _____ no When? _____

Briefly explain your current needs and hopes for therapy _____

(#1)Client or Authorized Person's/Guardian's Signature _____ (#2)Client or Authorized Person's/Guardian's Signature _____