



DrCFultz, LLC

Intake Form

The following form, which will become a part of your confidential record, will enable us to gain a quicker understanding of you. Please answer each question as completely and as carefully as you can. Please use the bottom of the last page for any additional information or comments.

Name _____ Date of Birth _____ Age _____ Sex _____

Present Address _____ Phone _____
Number Street

City _____ State _____ Zip Code _____
Cell Phone _____

Email address _____

Marital Status: Single _____ Married _____ (# of Years _____) Divorced _____ Separated _____ Widowed _____

Presently Living With: Parents _____ Spouse _____ Roommate _____ Alone _____ Other _____

Family Member to notify in case of Emergency:

Name _____ Address _____

Phones _____ Relationship _____

Occupation: _____ Total Hours worked per week _____

Employed by: _____ Years of Education: _____ Phone _____

Referred by: _____

Religious Affiliation _____ Pastors Name _____

Active Member _____ Inactive Member _____ Church You Attend _____

Members of Current Household: (living with you in the same house)

Relationship Name Age Last Grade Completed Occupation

Relationship	Name	Age	Last Grade Completed	Occupation

Are you currently receiving medical treatment? _____ If so, Doctors name: _____

Health Info: _____

Are you currently taking medications? _____ Please list Medications _____



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Previous Counseling/Therapy? _____ If yes, when? _____

Where & with whom? _____

Name

Title

Address

Phone

In your own words, briefly describe the main problem which prompted you to seek counseling at this time.

Have there been times when the problem got better or disappeared? Yes _____ No _____

If so, when? _____

Were there times when the problem was especially bad? Yes _____ No _____

Explain _____ Please list any persons you feel may have played a major role in causing your problems _____

Please list any person who helps you cope with your problems _____

Please check the type of counseling you desire:

Individual _____ Pre-marital _____ Marital _____ Child/Teen _____ Family _____ Divorce Recovery _____ Grief/Loss _____ Illness _____ Abuse _____ Domestic Violence _____ Anger Management _____ Stress Management _____ Sexual Issues _____ Emotional Healing _____ Relationships Other _____

I, _____ (print your name), have read the policy sheet, completed the intake form, and have submitted to counsel of my own free will. I recognize that the counselor is a Pastoral Counselors and may approach me with Christian or Biblical concepts and prayer. I will not hold Dr. Cheryl Fultz responsible for the outcome of therapy. (It is my choice to follow the counsel or not.)

Signature _____ Date _____

For clients 17 years and under, the signature of his/her guardian or custodial parent is required.

Signature of Parent or Guardian _____ Date _____

Comments or further information: