NÁOS
Spiritual Direction
Counseling

Phone: 720-507-8927
Web: naossdc.com

Client ID:_____

CONFIDENTIAL INTAKE FORM

Please fill out this information form as carefully and as thoroughly as possible. This information will be confidentially used by your therapist.

GENERAL INFORMATION:

_____ _____
NAME **AGE & DOB**

Name of Parent(s)/Guardian(s) if under 18: _____

EDUCATIONAL INFORMATION:
Highest level of schooling completed: ❑ High School ❑ College ❑ Graduate
❑ Professional training ❑ Currently a student, grade: _____ ❑ Other _____

OCCUPATIONAL INFORMATION:
Employment status: ❑ Full-time ❑ Part-time ❑ Unemployed ❑ Retired
❑ Receive Disability ❑ Other: _____

Place of employment: _____ Length of Employment:_____

FAMILY INFORMATION
Relationship Status: ❑ Single ❑ Engaged ❑ Married ❑ Separated ❑ Divorced
❑ Widow(er) ❑ Committed Partnership Date of Same:_____

Name of Spouse/Partner: _____

Parents: Mother: ❑ living (age ____) ❑ Deceased (date _____)
Father: ❑ living (age ____) ❑ Deceased (date _____)
Siblings: Number of Brothers [ ] Number of Sisters [ ] ❑ Only Child

Children: Please list Name(s), Age(s), By Present Marriage (P), Former Marriage (F), Adopted (A) and whether or not they live at home. _____

_____

Others who live with you:_____

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HEALTH:

Name, Address & Phone Number of current Primary Care Physician (PCP):

_____

Would you like coordinated treatment planning with provider?

❑Yes ❑No *Release Required

List any health issues/ illness(s)/ disabilities

_____

Current Medications:

Medication Name	Dosage	Frequency	Start Date	Prescribing Physician

Have you ever received psychotherapy, counseling or other treatment for personal and/or family problems?_____ When?_____

IMPORTANT QUESTIONS FOR YOU AND YOUR THERAPIST

Please describe your reasons for seeking help: _____

_____

How long have you been aware of this problem? _____

Who else knows about your problem(s)? _____