



Brenda Olsen, MA, LCPC

Date _____

Intake Form

Client's Name

First Name _____ Middle _____ Last _____

Male
Female

Spouse's Name

First Name _____ Middle _____ Last _____

Male
Female

Address

City

_____ State _____ Zip _____

Home Phone

() _____

Work Phone

() _____

Cell Phone

() _____

Date of Birth

/ /

Marital Status

Single Married Other

Highest Level of Education

Religious Affiliation

Occupation / Business

How did you hear about me?

Personal & Family History:

Client's Immediate Family Members:

Name	Relationship	Age	Name	Relationship	Age

Please describe any history of physical or mental health issues either in your current family or in your family of origin:

Any history of addictions? Yes No Give Details:

Have you ever had psychotherapy before? Yes No Reason:

Name of Therapist:

Dates:
