



# Jenna Perrine, MA, LPC

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:

\_\_\_\_\_

Are you currently on any medications?    Yes    No

Medication:	Prescribed By:	Dosage:	Date(s) of usage:
_____	_____	_____	_____
Medication:	Prescribed By:	Dosage:	Date(s) of usage:
_____	_____	_____	_____

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Any significant health changes in the past year?    Yes    No    Reason:

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What brings you to therapy at this time?

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**Notice of Privacy Practices,  
Payment & Cancellation Policies  
Receipt and Acknowledgment of Notice**

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Jenna Perrine's Notice of Privacy Practices, Payment & cancellation policies. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Jenna Perrine at 847-381-2700 or 1531 South Grove, Suite 204, Barrington, IL 60010

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Signature of Patient / Client

Date

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Signature of Parent, Guardian or Personal Representative\*

Date

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\* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Patient / Client Refuses to Acknowledge Receipt:

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Signature of Staff Member

Date