# *Nader Sahyouni, MS, 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: | |
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Any significant health changes in the past year? ☐ Yes ☐ No Reason:

What brings you to therapy at this time?

## 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 Nader Sahyouni'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 Nader Sahyouni at 847-381-2700 x416 or 1531 South Grove, Suite 204, Barrington, IL 60010

Signature of Patient / Client Date

Signature of Parent, Guardian or Personal Representative* Date

* 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:

Signature of Staff Member Date