



Thomas Purnell, 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: _____

Are you currently on any medications? Yes No

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

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 Thomas Purnell'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 Thomas Purnell at 847-701-4144 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