

## Intake Form

<b>Name:</b>	<b>Today's Date:</b>	<b>Date of Birth:</b>	<b>Age:</b>
<b>Address:</b>	<b>City, State and Zip:</b>		
<b>Phone number:</b>	<b>Email:</b>		
<b>Single / Married / Divorced</b>	<b>Spouse's Name:</b>		
<b>Emergency Contact:</b>	<b>Phone Number:</b>	<b>Relation:</b>	

**Do you currently see a therapist? If yes, please provide their name and contact information below.**

**Names and ages of those who live with you:**

Name		Age	Name		Age
Name		Age	Name		Age

**Health Issues: Tell me what's happening health wise for you right now.**

**Nutrition: How is your nutrition? – How it really is....not how you want it to be...**

**Exercise:**

**Medications:**

**Past and present life stressors:**

**Any family history that I should be aware of?**

SUBMIT