# Empowering Systemic Therapy, LLC

Client_____ Date_____

## Intake Information

Last Name First Name Middle Name

Street Address

City State Zip

Home Phone Work Phone Cell Phone
(circle preferred place to contact)

_____ _____ _____
Date of Birth Insurance Company Insurance Identification Number

Family Members in your home (please provide name, age, gender identity, pronouns and relationship):
_____
_____
_____
_____
_____
_____
_____
_____
_____

Emergency Contact (please provide name, best contact number and relationship):
_____

*Is it Ok to leave messages for you?* Please Circle YES NO

I certify that the above information is true and correct to the best of my knowledge

Signature of Client or Person Responsible for Client Date

Print Name

# Empowering Systemic Therapy, LLC

Client_____ Date_____

## Intake Form

Presenting Problem/Concern:

History of Problem/Concern (please include duration):

Current Support System:

Current Medical Issues (please include any current psychiatric medications):

Family History of Drug/Alcohol abuse and dependence, mental illness, suicide/homicide:

# Empowering Systemic Therapy, LLC

Client_____ Date_____

Goals of Therapy:

Previous Treatment:

Personal Strengths:

Please add any additional information that you feel could be helpful. Thanks!