720 Alhambra Blvd.
Sacramento, CA 95816
Phone: (916) 492-9007

Intake Questionnaire

Name(s)_____Date_____

Dependents/Minors Names (if in treatment)_____Age_____

_____Age_____ _____Age_____

Address_____City_____Zip_____

Home Phone_____ Work Phone_____ Fax_____

E-mail_____ Cell Phone _____

Date of Birth_____ Social Security #_____-_____-_____ Marital status_____

Education: High School Trade School Jr. College College Graduate Degree

Training/Skills_____

Employer_____ Job_____

Emergency contact information_____Phone_____

Would you like to be contacted for upcoming groups, classes and workshops? Yes___ No___

Method of Payment:

How do you intend to pay for treatment? Cash Check Credit Card EAP Insurance

EAP Provider _____ Intake/Authorization#_____

If planning to use health insurance:

Name of Insurance company_____ Policy #_____

Group # _____ Telephone # _____

Subscriber # _____(From Card) Authorization #_____

Areas of Concern:

What issues/concerns caused you to seek counseling? Please describe:_____

_____

_____

What are your specific goals with regard to your counseling? _____

_____