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:_________________________

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

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