

**Client Intake Form
ACTSolutions**

923 South Church Street, Grapevine Tx 76051 817.707.3329

Name: _____ Phone number to use to contact you: _____

Home Address: _____

Street Apt # City State Zip

Marital Status (circle one): Never married / Married (how long? _____) / Widowed: ___ / Separated (how long? _____) Divorced ___ (how long? _____) Please indicate number of marriages: _____

Date of birth _____ Age: _____ Gender: _____ Religious background (denomination): _____

Place of employment: _____ Position/title: _____

Number of hours per week: _____

Spouse's name if married: _____ Spouse's place of employment _____

Names of children living in your home:

Name Gender DOB AGE School/occupation Marital Status

List any children not living in your home:

Name Gender DOB AGE School/occupation Marital Status

Have you, your spouse, or children ever been involved in therapy or any type of counseling? YES/NO

If yes, please explain when, where, reason. Was it beneficial? _____

Were you referred to ACTSolutions? YES/NO If yes, by whom? _____

Are you in treatment with another counselor at this time? YES/NO If yes, who? _____

Name of facility/agency: _____ how long? _____

Issues/reason for treatment at this time:

List all medications you are currently taking: _____

Name of physician(s) who prescribed medications: _____ phone: _____

Person to contact in case of emergency: _____ phone: _____

What do you expect, hope to gain from therapy? _____

I certify that all information provided is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

SIGNATURE: _____ DATE: _____