

Door of Hope Counseling
1201 North Watson Road Suite 142
Arlington, Texas 76006

For Office Use Only: Referral Source _____ Ref # _____ # Sessions _____ From _____ To _____
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CLIENT INTAKE

Date of Contact: _____

Client Name: _____ DOB: _____

Client Address: _____
(Street, City, State, Zip)

Phone: () _____ () _____ () _____
Home Work Cell

Email address: _____ Male _____ Female _____

Ethnicity: ___Black ___White ___Hispanic ___Native American ___Asian/Pacific Islander ___other _____

Referred by: _____

Emergency Contact: _____

Relationship: _____ Home/Cell: _____

Name of employer _____

Address: _____

Telephone number: _____

Insurance: _____

Physician(s): _____

Concerns (What brings you to counseling?):

Medications (List any medications that you are currently taking.):

Previous Counseling or Therapy (List dates and therapist):

Medical History:

I hereby consent to treatment by this provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however for any balance due prior to a decision to discontinue.

Client Signature: _____ Date: _____