Door of Hope Counseling
1201 North Watson Road Suite 299
Arlington, Texas 76006

For Office Use Only:
Referral Source_____
Ref #_____
Sessions_____
From_____To_____

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: _____