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

Door of Hope Counseling

1201 North Watson Road Suite 177
Arlington, Texas 76006

CLIENT INTAKE

Date of Contact: _____/_____/_____

Client Name: _____ DOB: _____/_____/_____

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

Phone: ( ) _____ ( ) _____ ( ) _____
Home - OK to contact? Y / N Work -OK to contact? Y / N Cell – OK to contact? Y / N

Email address: _____Male _____ Female _____

Ethnicity: __Black __White __Hispanic __Native American __ Asian/Pacific Islander __ other _____

Referred by:_____

Emergency Contact: _____

Relationship: _____ Home/Cell: _____

Employer_____

Address: _____Telephone: _____

Insurance: _____ID#_____

Concerns (What brings you to counseling?):

_____
_____
_____
_____

Previous Counseling or Therapy (List dates and therapist):

_____
_____

Door of Hope Counseling

Family / Social / Medical History:

Family History of Mental Illness	____Yes	____No	_____
Significant Family Background Issues	____Yes	____No	_____
Sexual Abuse	____Yes	____No	_____
Physical abuse/domestic violence	____Yes	____No	_____
Trauma/Loss	____Yes	____No	_____
Lack of Support System	____Yes	____No	_____
Current Medications	____Yes	____No	_____
Physician	____Yes	____No	_____
Psychiatrist	____Yes	____No	_____
History of suicidal ideation	____Yes	____No	_____

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.

_____ _____/_____/_____

Signature Date