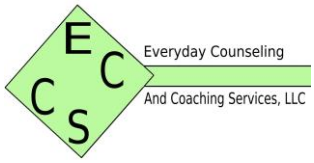

Everyday Counseling and Coaching Services, LLC
Orly Katz, LCPC, NBCC
1 Research Court. Suite 450
Rockville, MD 20850
(301) 660-6759
therapyorly181@gmail.com

Client Intake Form

Personal Information **Today's Date:_____**

Name: _____ Age: _____Sex: F M

Date of Birth: _____ Social Security # _____

Address: _____ City: _____ St: ___Zip: _____

Is it okay to mail to this address? Y N

Home Phone: _____ Work: _____Cell phone:_____

E Mail: _____

Referred to Therapy By:

Therapist: _____ Word of Mouth: _____

Physician: _____ Attorney _____

Website: _____ Business Card/ Brochure _____

Emergency Contact:

Name: _____ Address: _____

Phone: _____ Relationship: _____

Paying Responsible Party: _Client _Private Insurance _ Other Party

Relationship of other party to client: _____ Social Security # _____

Phone: Home_____ Mobile/Work _____

Address: _____

City: _____ State: ____ Zip: _____

Everyday Counseling and Coaching Services, LLC

Employer: _____ Address: _____

Living Arrangements:

__ Living Alone __With parents or Guardian __With Roommates __With in-laws

__With Spouse/Significant Other __In Group Home

__Other Arrangement (Please Specify) _____

Others Living in the Home: (including children)

Name	Date of Birth	Age	Relationship
1.			
2.			
3.			
4.			

Relationship Status:

__Married/Partnered How long? _____

__Single __Widowed __Divorced __ Separated __Engaged __Remarried

Education:

__ Some High School __High School (Graduated) __Trade/Professional School

__ College (AA) __College (no degree) __College (graduated)

__Graduate (no degree) __Graduate (degree) __Doctoral degree or equivalent

Employment:

__ Employed Full Time __Employed Part Time __Homemaker

__Unemployed (for how long?) _____

Current or Most Recent Employer: _____

How long have you worked in this position? _____

Medical History

Date of Last Physical Exam: _____

Everyday Counseling and Coaching Services, LLC

Doctor's Name: _____ Doctor's Number: _____

Doctor's Address: _____

City _____ State _____ Zip _____

Past or Current Medical Problems:

Major Illnesses _____

Accidents/Injuries _____

Operations _____

Other_____

Please list current medications, prescriptions or over the counter medications that you are taking:

_____

_____

_____

Ongoing medical Problems:

__ Breathing problems __Diabetes __High/Low blood Pressure __Herat Problems

__Bowel/Bladder Problems __Cancer __Eating Problems __Sleeping Problems

__Headaches __Muscle or Joint Pain __Seizures __Sexual Problems

For females: __ Problems with Menstruation

Other, Please explain: _____

History of Alcohol/Substance Abuse (past or present) __No

__YES, please explain _____

History of Suicide Attempt __NO

__YES, please explain_____

History of Physical/Sexual Abuse __NO

__YES, please explain _____

Source of Positive Social Support

Family, coworkers, friends _____

Have you ever been hospitalized for mental health concerns? __NO

__YES, please explain: number of times, when, how and what happened_____

Have you ever been involved with the legal system? __NO

__YES please explain

Reasons for Appointment:

__Anxiety __Grief/Loss __Sleep Concerns __Depression __Support System Concerns

__ Irritability __Anger __Suicidal thoughts __Thoughts of harming others

__Other, please explain _____

Family History

Does anybody in your family have a history of mental problems? __NO

__YES, please explain _____

Does anybody in your family has a history of drugs/alcohol problems? __NO

__YES, please explain_____

Has anybody in your family attempted or committed suicide? __NO

__YES, please explain _____

Please review your answers so far. Is there anything else you would like to add about yourself?

Thank you for taking the time to fill this form.