Fowler and Tidwell Counseling
and Jenai Tidwell, LPC
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Office: 832-831-8379 Fax: 832-831-8388

Client Intake Form

Name: ____ D.O.B.: ______________________

Address: ____ Social Security#: _____________________

____

Phone Number: ________________________________ Check if it is ok to leave a message: ________

Alternate Number:______________________________ Check if it is ok to leave a message: ________

Email address: _________________________________ Check if it is ok to send you an email: ________

Emergency Contact Name: _______________________________ Relationship: ____________________

Phone Number: _______________________

Is the client a minor (under 18 years of age)? ( ) Yes ( ) No
If yes, complete below.
Guardian: _________________________________ Relationship: ____________________

Address of guardian (if different than above):

Address: ____ D.O.B. ____________________

____

Employment Status:

( ) Full-Time ( ) Part-time ( ) Student ( ) Not Working

Names and Ages of Individuals living with client:

1.____

2.____

3.____

4.____

5.____

Medical Information:

Primary Care Doctor: _________________________ Psychiatrist:_________________________________

Last Visit to M.D. ____________________________

Medical Conditions: ____

____

Current Medications:

Medication	Dose	Last Taken	Prescribed By

Behavioral History:

Have you ever been diagnosed with a mental health condition? ( ) Yes ( ) No

If yes, what were you diagnosed with and when? ____

____

Have you ever been hospitalized for a psychiatric condition? ( ) Yes ( ) No

If yes, when and where? ____

____

What primary issue brought you to counseling today? _______________________________________

____

____

Do you have a history of suicide attempts or suicidal thoughts? ( ) Yes ( ) No

If yes, please describe. ____

____

____

Do you currently, or have you in the past, abused alcohol or other substances? ( ) Yes ( ) No

If yes, please list substance(s) abused and related history including treatment for the substance abuse:

____

____

____

Social History:

Who makes up your support network (friends, family, etc.)?: ____

____

Do you currently have any legal cases pending against you? ( ) Yes ( ) No

If yes, please describe: ____

____

____

How did you hear about my services? ( ) Referral from friend ( ) Professional Referral ( ) Internet

( ) Insurance Referral ( ) Other ___________________

____ ___________________

Client or Guardian Signature Date