Winning At Home

Confidential Intake Form

Today's Date: _____

Name: _____	**Name:** _____
Date of Birth: _____ **Sex: M**____ **F**____	**Date of Birth:** _____ **Sex: M**____ **F**____
Address: _____	**Address:** _____
City: _____ **ZIP:** _____	**City:** _____ **ZIP:** _____
Employer: _____	**Employer:** _____
Address: _____	**Address:** _____
Home Phone: _____	**Home Phone:** _____
Cell Phone: _____	**Cell Phone:** _____
Work Phone: _____	**Work Phone:** _____
Email: _____	**Email:** _____
Social Security #: _____	**Social Security #:** _____

Religious Affiliation: _____	**Marital Status:** Single _____ Married _____ Separated _____ Divorced _____ Widowed _____ Living Together _____

CHILDREN

Name	Age	School/Grade	Biological/Adopted

Name of anyone else living in the home: _____

MEDICAL HISTORY

Physician's name: _____ Date of last physical: _____

Are you currently being treated for any medical conditions? Y N If yes, please explain: _____

_____

Are you currently taking any medications? Y N If yes, please list: _____

_____

_____

Please list any allergies: _____

Have you received previous counseling? Y N If yes, by whom?_____ Date/Year: _____

Please briefly state why you are currently seeking counseling: _____

_____

REFERRAL INFORMATION

Referred by: _____ Address:_____

I would like to send a note of appreciation to the person who referred you for supporting our ministry. Please sign for your permission.

Signed: _____ Date: _____

COMMUNICATION AUTHORIZATION

I authorize Winning At Home Family Wellness Center to use the email and mobile number listed above to send changes and/or confirmations to my appointment schedule via text message or voicemail.

Signed: _____ Date: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Phone Number: _____ Relationship to Client: _____