Royanne Ukestad, LMFT
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408-776-1009

INTAKE INFORMATION Date: _____

Your Name: _____ Birthdate: _____ d/m/y Sex: M____F____

Address: _____ City: _____ Zip: _____

Occupation: _____ SSN#: _____ Drivers License #: _____

Employer: _____ Phone #: (W) _____ (H) _____ (Cell) _____

Marital Status: Single ___ Married ___ Separated ___ Divorced ___ Cohabiting ___ Religion _____ Relationship to Client: _____

Insurance: _____ Physician: _____ Medications: _____

EMERGENCY CONTACT: _____ Relation: _____ Phone #: _____

Alt #: _____

Spouse/Partner Name: _____ Birthdate: _____ Religion #: _____

Address: _____ City: _____ Zip: _____ SSN #: _____

Occupation: _____ Employer: _____ Phone #: (W) _____ (H) _____

Relationship to Client: _____ Insurance: _____ Physician: _____

****COMPLETE ONLY IF CLIENT IS CHILD OR ELDER****

Name: _____ Birthdate: _____ d/m/y Sex: M ___ F___

Occupational/School: _____ Grade: _____ Teacher: _____

School Counselor: _____ Physician: _____ Medications: _____

Medical Problems: _____

List Any Previous Therapeutic Interventions and Dates: _____

_____

_____

BRIEFLY STATE YOUR REASON(S) FOR SEEKING TREATMENT:

_____

_____

_____

_____

_____

WHO REFERRED YOU:

Name: _____ Address: _____ Phone: _____

May this referral source be contacted as a professional courtesy? YES_____ NO_____

(over)

Individual, Couple & Family Counseling; Assessment; Consultation

Rev 11/2010

FAMILY MEMBERS AND OTHERS LIVING AT HOME:

(Name)	(Age)	(Relationship)

FAMILY MEMBERS AND SIGNIFICANT OTHERS NOT LIVING AT HOME:
