

Individual Intake Form

Name: _____ Spouse/Partner's Name: _____

Address: _____

Telephone-Home: _____ Work: _____ Email: _____

1. Sex: Male Female

2. Age: _____ Years

3. Marital/Relationship Status:

- Single (never married)
- Significant Other
- Cohabiting (living together)
- First Marriage
- Separated
- Divorced
- Widowed
- Remarried (after divorce)
- Remarried (after spouse's death)

4. Current Employment:

- Full-time
- Part-time
- Homemaker
- Unemployed
- Full-time student
- Part-time student
- Retired

5. Approximate current annual household income:

- \$1,000-4,999
- \$40,000-49,999
- \$5,000-9,999
- \$50,000-74,999
- \$10,000-14,999
- \$75,000-99,999
- \$15,000-19,999
- \$100,000-149,999
- \$20,000-29,999
- \$150,000 and above
- \$30,000-39,999

6. Children (include biological, adopted, foster, step, etc.):

Name:	Sex:	Age:	Type (bio, step, etc.):	Custody?
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

7. Education

- grade school or junior high
- attending/attended college
- technical school degree
- attending/attended high school
- college graduate
- graduate degree (Masters)
- high school graduate
- attending/attended graduate school
- graduate degree (Doctoral)

8. Race/Ethnicity

- White (European American)
- Native American
- Asian American
- Black (African American)
- Black (Other)
- Mexican American (Latino)
- Other Latin or Spanish heritage
- Other: _____
- Multiracial

9. Are you presently under a physician's care? Yes No

If yes, what for? _____

List any current medications and amounts _____

Name and address of physician _____
