True Balance Counseling Collective, LLC

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Counseling and Therapy for Children, Adolescents, and Families

Client Intake Information

Client Name: ______________________ DOB: __________ Date of Intake:___________
Guardian's Name/Relationship:____
Address: _________________________________ City: __________________ Zip: _______
Numbers we may contact you to protect your confidentiality : Cell: ______________________
Work: ___________________ Home: ___________________ Best time to call: __________

Email Address: My therapist has permission to contact me by email to schedule appointments or to share helpful information that may be of interest to me. Yes ______ No _______
Email Address: ____

Emergency Contact: Name ____________________________ Relationship _____________
Phone: ____________________________
Where did you hear of our office?__________________________________
Why are you seeking help at this time?
____
Physician name: ________________________________ Phone: ______________________
Date of last exam:_____________________ Medications: ___________________________
Current Health Issues: ____
Psychiatrist:____
List names and ages of family members living with you:
____
____

Circle any of the concerns/problems below if they pertain to you:

anxiety	eating disorder	memory loss	sleep problems
depression	family violence	academic issues	appetite
alcohol Use	fears	anger/Conflicts	stress
drug use	obsessive/compulsive	loneliness	self-control
focusing	opposition	organization	social issues

Signature of responsible party:
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