Jeanine Siler Jones, LCSW
Intake Information Form

Name of Client_____ Today's Date_____
Address_____
City, State, Zip_____
Home phone_____ Social Security #_____
Work phone_____ Birth Date_____Birth Place_____
Email Address_____
Gender_____(preferred pronouns) _____ Age_____
Occupation_____Employer_____How long?_____
Religious affiliation: As a child_____Current_____
Faith Community_____ _____

Relationship status: Single___ Married___ Partnered _____Separated__ Divorced__ Widowed___

Children: Name Age Name Age

_____ _____

_____ _____

Partner/Spouse: Name_____Birth date_____Age_____
Social Security #_____Occupation_____Employer_____
Work phone _____

Family History:

Mother	Father
Name_____Age___ Deceased?___	Name_____Age___ Deceased?____
Married__ Separated__ Divorced__ Widowed___	Married__ Separated__ Divorced__ Widowed___

I was born the (first, second, third) _____of (two, three, four) _____children

Emergency Contact: Name_____Relationship_____
Address_____Phone_____Home__ Work__

Referral Source: Name_____ Title_____Agency_____
Address_____Phone_____
Do I have your permission to contact this person to thank them for the referral? Yes___ No___
Signed permission_____Date_____

(Please complete both sides of this form)

Problem or Stress Information:

What are you experiencing and/or what has happened to cause you to seek counseling?

_____

_____

Have you received previous counseling? Yes___ No___ Name of counselor(s) and date(s_____

_____

General Health Information:

Names of primary care physician/other physician(s) or specialist(s)_____

_____Date of last physical exam_____

Medications presently taking_____

Known allergies/adverse reactions_____

Dates of surgical/invasive procedures_____

_____

I agree to counseling by Jeanine Siler Jones, LCSW, who is licensed by the state to provide counseling for persons with individual, marital, or family problems. I am aware that Jeanine Siler Jones, LCSW does not provide medical or legal assistance or psychological testing.

I agree to payment of fees at each session by check or cash. **I agree to change or cancel appointments with a twenty-four (24) hour notice, or else pay for the missed appointment.**

I understand that the information shared by either the counselor or the counselee is confidential and cannot be release to anyone without written consent except under the following conditions provided by the law:

- Imminent Danger--the law states that if we judge that you are a danger to yourself or others, we are required to take action to prevent harm from occurring to you or to others.
  Child abuse--we are required, by law, to report all cases of actual or suspected physical, emotional, or sexual abuse or neglect of children to the Department of Social Services.

Signature_____ Date_____