

April Wise, M.F.T.
 23 Altarinda
 Suite #208
 Orinda, CA 9456

Client Intake Information

Name of Client	Home Phone	Business Phone	Cell Phone	Email
Social Security Number	Date of Birth	Age	Gender	Education
Street Address	Nearest Relative (Name & Address)			
City State Zip Code	In case of emergency, notify			
Occupation	Place of Employment			
Marital Status <input type="checkbox"/> Never married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated If married, how long? _____	Gross annual family income			
	Established Fees			
	Referral Source – Agency and/or individual			
	Other agencies involved			
Family Members (Spouse, children)				
Name	Age	Grade/Occupation	Relationship	Living at home? (Y/N)
Clients Family of Origin (Mother, Father, Brothers, Sisters)				
Name	Age	Grade/Occupation	Relationship	Living at home? (Y/N)
Presenting problem(s): (State in your own words the reasons for which you are requesting help)				
History of presenting problem(s):				
Medications:				