

Trinity Christian Counseling 36405 Harper Avenue Clinton Township, MI 48035 586-468-0401

Fax: 586-463-2389 counseling@trinityct.org www.trinityct.org/counseling

CLIENT INTAKE FORM

Name	Date	Birth date
Address		
Home phone	Cell phone	
Ok to leave detailed voice messages?	Cell Home Wo	ork
Email		
Married Y N How long?	Previous Marriage Y	N How long?
Spouses Name		
Previous Marriage for spouse Y	N	
Children and/or stepchildren? Pleas	e indicate relationship and ages	below.
Highest level of education completed		
Employer name		
PCP name		
Address		
Phone Number		
When did you last see your Primary Ca	are Provider	
When was your last complete physical	l exam?	
How would you rate your overall healt	th? Excellent Goo	od Fair Poor

Do you have any chronic medical conditions?
What medications or supplements do you take on a daily basis?
Do you exercise? Y N N What type of exercise? How often?
Do you drink alcohol? Y N How many drinks and how often? Do you smoke? Cigarettes cigars Marijuana How much per day? Do you chew tobacco? Y N Do you Vape? Y N Religious affiliation Do you consider yourself a spiritual person? Y N Please explain:
In what areas of your life do you feel most confident?
In what areas of your life do you feel least confident?
Why are you seeking counseling?
What efforts have you used to resolve this issue?
Have you had counseling in the past?

abuse, death, illness.)	hat may help guide me in achieving your counseling goals. (I.e.	
Emergency contact Name	Relationship	
Insurance Information		
Insurance carrier		
Subscribers name	Date of birth	
Contract number	Group number	
Signature		
	herby understand that if my insurance will not coversian Counseling that I will be responsible for any payment in full the countries of th	
Thank you,		

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