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CLIENT INTAKE FORM

(PLEASE PRINT)

Date: _____

Referred By: _____

Name: _____

Address: _____

E-Mail Address: _____

Phone: Home _____ Work: _____ Cell: _____

May we contact you at your: Home ___ yes ___ no Work ___ yes ___ no

Sex: M _ F _ Date of birth: _____ Age: _____

Social Security Number: _____ DL # _____

Marital status: _____ If married, how long? _____

Spouse name: _____

Your employer: _____ How long: _____

Job title/position: _____

Religion as a child: _____ Currently: _____

Signature of legally responsible adult: _____

People currently in household including yourself:

	<u>Name</u>	<u>Relationship</u>	<u>Age</u>	<u>Sex</u>	<u>Educational Level</u>
1	Self	_____	_____	_____	_____
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____

Children living out of the home

Age

Age

In your own words describe why you are seeking counseling:

Whom have you previously consulted about the problem(s)?

(Names and Dates) _____

Are you currently seeing another mental health professional?

(Names and Dates) _____

List any medication(s) you are currently taking _____

Name of Local Friend or Relative (not living at same address)

Relationship to Client	Home Phone No.	Work Phone No.

I understand that I am responsible for my fee payment at the time of each appointment. I agree to be responsible for the full payment of fees for services rendered.

x

CLIENT/GUARDIAN SIGNATURE DATE

I hereby consent to treatment by specified provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.

x

CLIENT/GUARDIAN SIGNATURE DATE
