# DC VA Counseling Psychotherapy, LLC

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## CLIENT INTAKE FORM

Please provide the following information for my records.
Leave blank any question you would rather not answer or does not apply to you.
Information you provide here is held to the same standards of confidentiality as our therapy.
**Please fill out this form and bring it to your next session.**

**Name:**_____
(Last) (First) (Middle Initial)

**Birth Date**: _____ /_____ /_____ Age: _____

**Gender:** Male Female Other

**Address:**

_____
(Street and Number)

_____
(City) (State) (Zip)

**Home Phone**: ( ) **Cell/Work Phone** ( )

**Email:** _____ May I email you? Yes No

I give permission to be called/text at: HOME: Yes__ No___ CELL/WORK: Yes__ No__

Please Initial_____

**Emergency Contact**:_____ **Emergency Contact Phone**: _____

**Marital Status:**
Never Married Partnered Married Separated Divorced Widowed

**Number of Children:** _____ Ages:_____

**How did you hear about us? (Referred by/Found us on:**

_____
**Current reason for seeking therapy**:
_____

_____