Third Coast Wellness, P.C.
1300 W. Belmont Ave Suite 407
Chicago, IL 60657
(312) 560-9005

ICD-10: _____

INTAKE INFORMATION

Name:_____
Address: _____ Zip code: _____
Home Phone: _____ Cell Phone:_____
E-mail address: _____
Emergency Contact/Phone: _____
Age/DOB: _____

Marital/Commitment Status: _____ If so, how long? _____
Does partner know your pursuing therapy? _____
Partners Name: _____
If divorced or widowed how long? _____
Children: _____ Age of Children: _____
Can I leave a message: Home: Y__ N__ Work: Y__ N__ Cell: Y__ N__

Currently Employed? _____ If so, how long? _____
Occupation: _____
Name of current employer: _____
Nature of work: _____
Annual income (for sliding scale purposes): _____

Partners occupation: _____
Partners annual income (for sliding scale purposes): _____
Nature of reason you are seeking services now?
_____
_____
_____

Previous therapy? _____
If so did you work on similar issues?
_____
_____

Did you find therapy helpful? _____

How so?

_____
_____
_____

What do you hope to get out of therapy now? _____
_____
_____
_____

Are you currently taking prescription medication? _____
If so, which one(s): _____ for what? _____
Have you ever been hospitalized for psychiatric reasons? _____
If yes, when?_____ for how long? _____

Is alcohol or drug use an issue in your family of origin? _____
Is it something with which you struggle? _____

Identify what you consider to be the personal strengths and inner resources you bring to therapy?

_____
_____
_____
_____

Limitations, liabilities or weaknesses? _____
_____
_____
_____

How were you referred to me? _____

Can I mention your name when I thank the person who referred you? _____

Client Signature: _____

Client Signature: _____