Tammy A. Summers, M.Ed., LCMHC, NCC

919-659-5570 office 919-782-4770 Fax

Intake Date_____ Referred by:_____

Client Information

Name_____ Cell# _____ Email _____

Home Address _____
(Street) (City) (State) (Zip)

Age _____ Date of Birth _____ Sex _____ Education: _____

Marital Status _____ If Married, Mo/Yr _____ Divorced or Separated, Mo/Yr _____

Employer _____Work Phone_____

Spouse/Parent _____Phone#_____

Names/Ages of Children _____

Religious/Spiritual Preference _____Church Affiliation _____

Primary Family Physician _____

Current Medications/Dosage _____

_____

Past/Current Medical Problems_____

_____

Have you ever had a Head Injury __Y __N If yes, when: _____ Diagnosis and Treatment_____

_____

Date of last Physical_____ Blood Panel Taken __Y __N Any findings from labs that may be useful in our work? _____

What Presenting issues led you to seek counseling at this time? _____

_____

Have you received previous counseling? _____Y _____N

If yes, when? _____ From Whom? _____

Emergency Contact _____Phone _____