Kerry Billingham, MS, LMHC

Individual & Family Therapist

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Intake Form

Date _____

Last Name _____ First Name _____

Address _____ City _____ State _____ Zip _____

Email Address _____ Do I have permission to email you? Y / N

Phone _____ Alt Phone _____

DOB _____ Sex _____M _____F

Are you currently taking medications? Y / N If yes, then please list _____

_____

Name of Prescriber _____Phone Number _____

Have you ever seen a therapist in the past? Y / N
If yes, please give the name, date, and location of the therapy and briefly explain the nature of the problem.

_____

_____

How were you referred to my office?_____

Emergency Contact/Relation:_____ Phone:_____

Please circle any of the following struggles that pertain to you:

Anxiety	Depression	Fears/Phobias	Eating Disorders	Sexual Problems
Suicidal Thoughts	Separation/Divorce	Relationships	Finances	Drug/Alcohol Use
Career Choices	Anger	Self-Control	Unhappiness	Insomnia
Religious Matters	Work/Stress	Health Problems	Cutting/Self-Mutilation	Thought Patterns

Other: _____

_____ _____

Client Signature **Date**