

# Intake Form

Tom Linde, M.S.W.

Intake Date: \_\_\_\_\_

Your name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Home address: \_\_\_\_\_  
\_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Cellular phone: \_\_\_\_\_ Message OK? \_\_\_\_\_

Children: Name: \_\_\_\_\_ Age: \_\_\_\_\_ Lives at home? \_\_\_\_\_  
Name: \_\_\_\_\_ Age: \_\_\_\_\_ Lives at home? \_\_\_\_\_  
Name: \_\_\_\_\_ Age: \_\_\_\_\_ Lives at home? \_\_\_\_\_  
Name: \_\_\_\_\_ Age: \_\_\_\_\_ Lives at home? \_\_\_\_\_  
Name: \_\_\_\_\_ Age: \_\_\_\_\_ Lives at home? \_\_\_\_\_

Spouse/Partner name: \_\_\_\_\_ Age: \_\_\_\_\_

Home address: \_\_\_\_\_  
(if different)



Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Medical Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Work / Usual Occupation: \_\_\_\_\_



Referred by: \_\_\_\_\_

Purpose for seeking therapy at this time: \_\_\_\_\_

\_\_\_\_\_

Therapy goals: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other important information: \_\_\_\_\_  
(Continue on reverse if needed)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_