Rebekkah Alexander, M.Ed., LPC, CRT (LPC TX 14061)
Natural and Holistic Approaches to Personal Growth
P. O. Box 101503 ♦ Ft. Worth, TX. 76185
817-602-1513
info@rebekkahalexander.com

Intake Form

Today's Date: ________________________

Your Name: ____

Birth Date: ___________________________

Home Phone: ________________________ Work Phone: ____________________________

Cell Phone: ___________________________ Email: ___________________________________

Home Address: ____
Number and Street

____
City, State and Zip

Mailing Address if different from above: ____
Number and Street

____
City, State and Zip

Which phone number, email or address do you give permission to receive a message, email, or other correspondence? ____

Highest Education Received: ____

Occupation: ____

Relationship Status:

- ❑ Single
- ❑ Married/Date: _________________
- ❑ Living with Partner/Date: ________
- ❑ Separated/Date: _______________
- ❑ Widowed/Date: _____________
- ❑ Divorced/Date: ______________
- ❑ Remarried/Date: _____________
- ❑ Other/Date: _________________

How did you hear of our office? ____

Name of Spouse/partner: ____

Birth Date: ___________________________

Home Phone: _________________________ Work Phone: ___________________________

Cell Phone: ___________________________ Email: _________________________________

Home Address: ____
Number and Street

____
City, State and Zip

Names of Children (if any)
1. ____ Birth Date: _______________
2. ____ Birth Date: _______________
3. ____ Birth Date: _______________
4. ____ Birth Date: _______________

List by name the members of your family of origin in the order of their age, beginning with the oldest parent:

Name	Age	Male or Female	Current Level of Education
____________________________________	________	________	__________________
____________________________________	________	________	__________________
____________________________________	________	________	__________________
____________________________________	________	________	__________________
____________________________________	________	________	__________________
____________________________________	________	________	__________________

You were raised by:
_______ Both biological parents
_______ Mother and Stepfather
_______ Father and Stepmother
_______ Relatives
_______ Adoptive parents
_______ Mother Only
_______ Father Only
_______ Foster Home
_______ Other (Explain) ____

What is your current living status? ____

Local person to contact in the event of an emergency:

Name: ____ Relationship: ______________________

Phone Number: _____________________________________

Family doctor: ______________________________________ Phone: ___________________________

Please list any illnesses or medical conditions: ____

____

____

Are you currently taking any medications? ______ Yes ______ No

If yes, what and for what condition(s): ____

____

Have you ever or are you currently involved in any kind of therapy, counseling or other mental health treatment at another setting or clinic such as (please check all that apply):

- ❑ marital therapy
- ❑ family therapy
- ❑ individual therapy
- ❑ group therapy
- ❑ in or out patient treatment for drugs or alcohol
- ❑ in or out patient treatment for an eating disorder
- ❑ in or outpatient therapy for any psychological or emotional issue

Where and with whom? ____

____

When? ______________________________ Was the experience helpful? ___________________________

In what way was the experience either helpful or not? ____

____

Your reason for seeking counseling today: ____

____

What do you hope to accomplish with your sessions? ____

____

Is there anything else you would like me to know? ____

____