Diane Coté, LCSW

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Client Intake Form

Today's Date ____

Name ____

Address ____

Daytime Phone ____

Evening Phone ____

Cell Phone ____

Is it okay for me to call you on these numbers and leave a message? Yes____ No ______

Please comment on any phone restrictions____

E-mail address____

Is it okay for me to contact you on e-mail at home and/or work? Yes______ No_______

Age _____ Date of Birth ____

Employment & Position (if working)____

Employers Address ____

How long at this job? Years _____ Months ______

Health Insurance Plan & Phone Number____

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Social Security Number ____

Subscriber ID Number ____

Group Number ____

Co-Pay and Coverage Benefit ____

Primary Care Physician ______________________________ Phone ___________________

Date of last medical check-up ____

List any health problems and current medications ____
____

Current Living Situation ____
(live alone, roommate, partner, spouse, children family members, pets, etc.)

Emergency Contact _________________________________ Phone ___________________

Emergency contact's relationship to you ____

Education

High School _____ Some College _____ BA/BS _____ Master's + _________________

If you attended college; name of school, city and state, your major and minor: ____________________________________
____
____
____

Do you have a fertility related issue? Yes_______ No______

Please give brief overview: ____

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Have you been in counseling before? Yes _____ No _____

If yes, for how long and was it a good experience?____

What are your goals? ____

What are your personal strengths? ____

What are your personal challenge areas? ____

How did you hear about me?____