



Intake Information

Welcome to Rawers Therapy! If there is any information you are not comfortable giving in this format, leave it blank and we can discuss in person.

Name: _____ Age or Date of Birth: _____

Soc. Sec. # (if using Tri-Care): ____-____-____ (please have benefits card ready)

Best Phone Contact: (Home/Cell/Other): __ (____) ____ - _____

Street Address: _____

City: _____ Zip: _____ E-mail: _____

Please describe the reason you are seeking counseling:

Have you undergone any counseling or used any psychological services in the past?

Please list any prescription medication you are using, or have taken in the past 12 months:

Who lives at your home: (if applicable) Please list names, ages, and your relation:

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Printed Name

Signature

Date

Printed Name

Signature

Date