Intake Form

Lizanne Corbit, MA, LPC, NCC
Licensed Professional Counselor

Date: _____ Referred by: _____

Name: _____ Phone (h): _____

(o): _____

(m): _____

Address: _____

_____

Email: _____ Date of Birth: _____

Brief description of current problem or reason for seeking counseling or coaching:

_____

_____

Physician's Name: _____

Health Problems (if any): _____

_____

Current Medications: _____

Occupation: _____

Marital Status: _____ Previous Marriages: _____

Spouse's Name: _____ Dates of Marriage(s): _____

Names and Ages of Child(ren) or Pets: _____

_____

_____