Jessica Guenther
MSW, LCSW
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720-795-5255

PATIENT INTAKE INFORMATION

Please **PRINT** Date: _____

Name: _____

Address: _____
Street City State ZIP

Home Phone: _____ Email Address: _____

Occupation: _____

Birth Date: _____ Age: _____Birth Order in Family: # _____ of _____

Marital Status: Single ___ Married ___ Widowed ___ Divorced ___ Separated ___
Engaged___ Other (please describe) _____

Immediate Family Members (list only those residing with you):

Name	Age	Relationship to Client

Emergency contact:
Name Phone

_____

Medications presently taking and dosage: _____

_____

Physician: _____
Name Address Phone

List any previous counseling experience:

Counselor's Name	Dates	Address/Phone	Reason for counseling