CLIENT INTAKE FORM
Date ________________

For therapy services with Jennifer A. Watts, Ph.D., LMFT
1762 Century Boulevard NE, Atlanta, GA 30345

GENERAL INFORMATION – please print

Last name _________________________________ First name ________________________ MI ______

Birth date _____/______/_______ Age ____ Sex/gender identity and pronouns: ___________

Referred by (if internet, which site/s?) ____

If a personal/professional referral, may I thank the person? ❑Yes ❑ No

Street Address ____
(street) (city) (state & zip)

	preferred	ok to leave message?
Cell phone ________________________	❑	❑
Home phone ______________________	❑	❑
Work phone_______________________	❑	❑
Email address ____		❑

Place of Employment_____________________________ Length of Employment ____________________

Type of work you do____

Highest level of education completed: ❑ High School ❑ College degree ❑ Graduate degree ❑ Professional training ❑ Other ________________________

Relationship status: ❑ single ❑ married/partnered ❑ living together ❑ divorced ❑ widowed

Spouse/partner's: Name________________________________ Telephone _______________________

Others living in your home (Names/Relationship/Age): ____

____

In case of emergency, contact ____

Relationship __________________________________ Emergency phone __________________________

COUNSELING CONCERNS / MEDICAL AND PSYCHOLOGICAL HISTORY

Check any of the following that apply to you and explain

___ Depression____

___ Alcohol____

___ Drug abuse____

Please Note: I do have a 24-hour cancellation policy.
Appointments not cancelled with at least 24 hours notice will be charged at the full rate.

___ Other addictions ____

___ Serious illness ____

___ Violence ____

___ Suicide thoughts ____

Are these currently being treated? yes ____ no ____

By whom? ______________________________________

Their phone ( ) ______________________________ May I contact them? yes ___ no ___

Have you ever been in therapy before? yes ____ no ____

With whom? _____________________________________ When? ____________________________

Their phone ( ) ______________________________ May I contact them? yes ___ no ___

What medications are you currently taking (and for what condition(s)?____________________________

____

How will you know when your therapy is successful?

____

____

Realistically, how long do you think this might take? ____

Payments and Cancellations

I agree to pay for my treatment at the time of service.
I agree that if I cancel an appointment without at least 24 hours' notice, I will pay for the time that was saved for me.

Date ____________________

Signature ____

Print your name ____

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