

Lakewood Counseling Services

Client Intake Information

Name: _____ Date: _____

Address: _____ City: _____ Zip: _____

Telephone: _____ Cell: _____

E-mail: _____ Gender: Male Female

Birthdate: _____ Social Security Number: _____

Employed by _____ Position: _____

School _____

Medical Doctor: _____ Phone: _____

Medical Doctor Address: _____

Emergency Contact: _____ Phone: _____

single married committed relationship divorced separated widowed

If applicable, Parent or Guardian: _____

Parent or Guardian Phone: _____

Reason for Appointment: