

**CLIENT INTAKE FORM**

For therapy services with Jennifer A. Watts, Ph.D., LMFT  
25-B Lenox Pointe, N.E., Atlanta, GA 30324

Date \_\_\_\_\_

**GENERAL INFORMATION – please print**

Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_

Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

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)

Cell phone \_\_\_\_\_ preferred ok to leave message?

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**

Why are you seeking therapy now? \_\_\_\_\_  
\_\_\_\_\_

What would you like to see happen as a result of psychotherapy? \_\_\_\_\_  
\_\_\_\_\_

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.

**MEDICAL AND PSYCHOLOGICAL HISTORY**

Have you received psychotherapy or counseling in the past?  No  Yes

If so, when and with whom? \_\_\_\_\_

\_\_\_\_\_  
Psychiatrist's name and phone number: \_\_\_\_\_

List current medications: \_\_\_\_\_

\_\_\_\_\_  
Physician's name and phone number: \_\_\_\_\_

Date of last physical: \_\_\_\_\_

List physical illnesses or symptoms: \_\_\_\_\_

\_\_\_\_\_  
List current medications: \_\_\_\_\_

\_\_\_\_\_  
Have you or any member of your family received help for drug or alcohol dependency?

No  Yes Who? \_\_\_\_\_ When? \_\_\_\_\_ Where? \_\_\_\_\_

\_\_\_\_\_  
Have you or any member of your family been hospitalized for mental/emotional/psychiatric reasons?

No  Yes Who? \_\_\_\_\_ When? \_\_\_\_\_ Where? \_\_\_\_\_

**OTHER**

Please provide any other information you think will be necessary or helpful: