Intake Information

Name_____

Home Address_____

City_____ State_____Zip_____

Day Phone_____ Evening Phone_____

Date of Birth_____ Cell Phone_____

Employer's Name_____

Social Security Number_____

Occupation_____ Marital Status_____

Please list the members of your household: Names and Ages

_____

_____

_____

Emergency Contact: _____Phone:_____
Cell Phone:_____Relationship:_____

Who Referred You?_____

May I contact them to thank them?
Yes___ No___ If yes, please write their phone # or address:_____

Concerns causing you to seek counseling: (Use back of page if needed.)

Previous counseling or therapy (Please list clinicians and dates):

Melissa Britt Perrin, Psy.D. 2530 Crawford Ave. Evanston, IL. 60201
Phone: 847-864-8874 or fax: 847-864-8875

Current prescription medication and purpose?

Please list stressors in the past year (e.g. divorces, new baby, losses, death, new home, new job, illnesses of significant other or self, etc.)

Please list current support network (e.g. family, friends, sponsor, spiritual connections, etc):

Please list goals for treatment:

How long do you estimate being in treatment?

Party Responsible for payment:_____

Address of Responsible Party:_____

I understand that the person responsible will be charged directly and that they are responsible for payment of the fees. Insurance forms will be completed upon request so I can receive available reimbursement for my treatment. I understand that payment is due at the time of service.

Signature_____

Witness_____