Intake Information

Rebecca M. Ashe, LICSW

Date:_____

Name:_____DOB:_____

Street Address:_____Address2:_____

Town:_____State:_____Zip:_____

Phone:_____Work Phone:_____ e-mail:_____

Employed By:_____ Position:_____

Referred By:_____ Relationship:_____

Brief Statement of Reasons for Coming:_____

_____

_____

_____

Family (Currently residing with you)

Name	Sex	Age	Relationship
1. _____	M/F	_____	_____
2._____	M/F	_____	_____
3. _____	M/F	_____	_____
4. _____	M/F	_____	_____
5. _____	M/F	_____	_____
6. _____	M/F	_____	_____

History of Psychiatric Hospitalizations:

_____

History of Psychotherapy:

Therapist	Address/ Phone	Dates

History of Drug/ Alcohol Treatment:

Doctor:_____Address:_____

Medical Problems:_____

_____

_____

Current Medications:_____

_____

Signature:_____Date:_____