SARAH MCCRACKEN, LICSW, CIMHP

INTAKE INFORMATION

Client's Information:

Last Name: _____ First Name: _____M. I.:____

Street: _____

City: _____State: _____ Zip: _____

Phone: _____

Date of Birth: _____ Marital Status: S M D W CU

Gender: _____ Pronouns:_____

Employer: _____ Occupation: _____

Person to Contact In Case of an Emergency:

Name: _____ Relationship: _____ Tel: _____

Contact Information for Clients under 18 years of Age:

Parent/Guardian: _____

Home Phone: _____May I leave a message at this number? Yes No

Cell Phone: _____ May I leave a message at this number? Yes No

Work Phone: _____May I leave a message at this number? Yes No

Email: _____

Additional Parent Guardian: _____

Home Phone: _____May I leave a message at this number? Yes No

Cell Phone: _____ May I leave a message at this number? Yes No

Work Phone: _____May I leave a message at this number? Yes No

Email: _____

Additional Parent Guardian:

Home Phone: _____May I leave a message at this number? Yes No

Cell Phone: _____ May I leave a message at this number? Yes No

Work Phone: _____May I leave a message at this number? Yes No

Email: _____

School Information:

School: _____ Grade: ____ Teacher: _____

Classroom Setting: _____

IEP: Yes No

Interventionist: Yes No

504 Plan: Yes No

Referring Physician: _____

Reason for Referral

Please take a moment to explain the reasons you are seeking psychological support. What concern is bringing you and/or your child into care?

Goals for Treatment:

Please explain what you and/or your child are hoping to gain from treatment.

Person Completing Form: **Date:**