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Intake Form

Client(s) Full Name: _____

Date: _____ Age: _____ Gender: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Numbers: _____

Do you give consent for therapist to leave message if needed: Yes No

Emergency Contact Information

Name: _____

Relationship to you: _____ Phone: _____

Marital Status: Single / Married / Divorced / Separated / Widowed / Living Together / Dating Since: _____

Race/Ethnicity: _____ Religion/Spirituality: _____

Occupation: _____ Referred to CTPC by: _____

Persons living in your home (Name, Age, Relationship to you):

Important persons not living in your home (family, friends, children, partners, etc):

What brings you to counseling at this time:

Please describe the nature of your problem in specific terms (onset, frequency, intensity):

How have you coped? What are your attempts to resolve situation:

Current health condition:

Current medications:

Past major illnesses or injuries:

Past psychotropic medications:

History of mental health of self and family (include counseling, psychiatrists, psychologists, school counselors, hospitalizations, drug/alcohol rehabilitation experiences):

May I contact previous mental health providers to obtain useful information if needed: _____
Personal history (include siblings, parents, children, significant childhood experiences and memories,

significant relationships, current relationships, significant life changes):

History of sexual, physical, or emotional abuse witnessed or experienced (self and/or family members):

History of and current drug or alcohol use (self and/or family members):

History of and current problems with eating (self and/or family members):

History of and current legal issues:

Other relevant issues:
