6135 King Road, Suite D, Loomis, CA 95650
Phone: 916-676-7405 Fax: 916-471-0559
www.heartstringscounseling.org

Counseling Application/Intake Form

Have you been referred to a particular counselor? ☐ Yes ☐ No

Name of counselor you were referred to_____

Who referred you?_____

This application is for:

☐ **Marriage and/or Couples Counseling** ☐ **Individual Female** ☐ **Individual Male**

☐ **Parent and Child** ☐ **Family** ☐ **Other**

Name _____ Date of Birth _____

Spouse_____ Date of Birth _____

Child _____ Date of Birth _____

Address_____

City_____ State_____ Zip _____

Home#_____ Cell#_____ Email _____

Marital Status

☐ Single ☐ Living together for_____ years ☐ Married for _____years

☐ Divorced for_____ years ☐ Widowed for _____years

Your Employer

Occupation _____ Work#_____

Spouses Employer _____

Emergency Contact: Name _____ Contact #_____

Relationship_____

Counseling History

Have you ever consulted a counselor, psychotherapist or psychiatrist before? ☐ Yes ☐ No

Name of therapist:_____

Dates seen (from when to when):_____

Reason:_____

HEARTSTRINGS COUNSELING
A NON-PROFIT AGENCY

Medical History:
Have you taken, or are you now taking, any prescription medications for mental health issues

☐ Yes ☐ No

What prescriptions?_____

For how long?_____

Prescribed by whom and for what conditions?_____

Please give a brief summary of the **specific reason** you are seeking counseling at this time. Be assured this information is confidential and will be used only for the purpose of assigning you to the appropriate counselor.

_____

_____

_____

_____

_____

_____

Appointment Availability: Please **circle** the days and time periods **YOU ARE ABLE TO ATTEND**.

DAY : M T W TH F S Sun 8:00 am to noon noon to 5:00 pm 5:00 to 9:00 pm

I would like biblical principles incorporated into my counseling sessions.

☐ Yes ☐ No ☐ I don't know

I would like to request a handicap accessible room and I cannot walk upstairs.

☐ Yes ☐ No

Choose your payment option below:

☐ **I am ABLE to pay the reduced clinical counseling fee of $85.**

☐ **I am UNABLE to pay the above fee and wish to use for the SLIDING FEE SCALE (based on my monthly income).**

☐ **I would like to be referred to a licensed Marriage and Family Therapist for $90/ Session.**

Print Name _____

Signature _____ **Date** _____