



# WILLOW THERAPY

## Counseling Intake Form

### CONTACT INFORMATION

First Name:	MI:	Last Name:
Birth Date:	Age:	
Address:		
Cell Phone: _____ - _____ - _____		Home Phone: _____ - _____ - _____
Email Address:		
Relationship Status:    Single    In Relationship    Married    Seperated    Divorced		
Parent/ Guardian's Name (If applicable):		
Who Referred You?		

### EMERGENCY INFORMATION

Emergency Contact:	Emergency Contact Phone: _____ - _____ - _____
Primary Physician:	Physician's Phone: _____ - _____ - _____

### CONSENT TO TREAT

Signature: _____	Date: _____
Parent/ Guardian Signature (If under 15 years of age): _____	Date: _____