



**Fowler and Tidwell Counseling**  
7155 Old Katy Road Suite N244  
Houston, TX 77024  
Office: 832-831-8379 Fax: 832-831-8388

## Client Intake Form

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Address: \_\_\_\_\_ Social Security#: \_\_\_\_\_  
\_\_\_\_\_

Phone Number: \_\_\_\_\_ Check if it is ok to leave a message: \_\_\_\_\_

Alternate Number: \_\_\_\_\_ Check if it is ok to leave a message: \_\_\_\_\_

Email address: \_\_\_\_\_ Check if it is ok to send you an email: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Is the client a minor (under 18 years of age)? ( ) Yes ( ) No

If yes, complete below.

Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address of guardian (if different than above):

Address: \_\_\_\_\_ D.O.B. \_\_\_\_\_  
\_\_\_\_\_

Employment Status:

( ) Full-Time ( ) Part-time ( ) Student ( ) Not Working

Names and Ages of Individuals living with client:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

**Medical Information:**

Primary Care Doctor: \_\_\_\_\_ Psychiatrist: \_\_\_\_\_

Last Visit to M.D. \_\_\_\_\_

Medical Conditions: \_\_\_\_\_

Current Medications:

Medication	Dose	Last Taken	Prescribed By

**Behavioral History:**

Have you ever been diagnosed with a mental health condition? ( ) Yes ( ) No

If yes, what were you diagnosed with and when? \_\_\_\_\_

Have you ever been hospitalized for a psychiatric condition? ( ) Yes ( ) No

If yes, when and where? \_\_\_\_\_

What primary issue brought you to counseling today? \_\_\_\_\_

Do you have a history of suicide attempts or suicidal thoughts? ( ) Yes ( ) No

If yes, please describe: \_\_\_\_\_

Do you currently, or have you in the past, abused alcohol or other substances? ( ) Yes ( ) No

If yes, please list substance(s) abused and related history including treatment for the substance abuse:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Social History:**

Who makes up your support network (friends, family, etc.)?: \_\_\_\_\_  
\_\_\_\_\_

Do you currently have any legal cases pending against you? ( ) Yes ( ) No

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How did you hear about my services? ( ) Referral from friend ( ) Professional Referral ( ) Internet  
( ) Insurance Referral ( ) Other \_\_\_\_\_

\_\_\_\_\_  
Client or Guardian Signature

\_\_\_\_\_  
Date