# LIFE SKILLS PLUS, INC INTAKE INFORMATION

**Welcome. Please fill out the following information**

## ADMINISTRATIVE INFORMATION

PATIENT'S NAME (Last Name, First Name, Middle Initial)_____ Date:

PATIENTS ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ Holme Phone _____

Cell Phone Work or School Phone Emplyer or School

3. PATIENT'S BIRTH DATE _____ Age: _____ ☐ MALE ☐ FEMALE Medicaid #

SS# _____ Place of Birth _____ Race: _____

Responsible Party: If a minor. _____

Highest Grade Completed: _____ Degree Earned: _____ Field of Study: _____

Advanced Directive? Advanced Directive Brochure?

Referred By? _____

Internet Site? _____

Start Date: 9/20/2017

DATE OF FIRST CONTACT FIRST AVAILABLE DATE Within 7 Days

**Current Symptoms:** _____

**Duration** _____

**Intensity** _____

Emergency Contact:

Name Phone # Address

## CURRENT FAMILY INFORMATION

Father: Father's age: Mother: Mother's age:

| Child's age | Children's Name: | Children's Symptoms: | School, Address |
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People currently living with:

**Relationship risks and legal issues.**

**Discribe the problem that brings you in for therapy.**

Marital Status: Date of Marriage: Spouses Name:

Separated? Divorced?

Nearest Friend Relative: Friend's Phone #

Friend's Address

Father's Employer: Employer's Address:

Father's Position: Employer's Telephone:

Mother's employer: Mother's Employment Address:

Mother's Position: Mother's Employment Telephone #

Yearly Family Income