Michael J. Maxwell, PhD, LPC-S, NCC

Licensed Professional Counselor

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Lewisville, TX 75057

Initial Intake Form

NAME: _____ GENDER: _____DATE: _____

ADDRESS: _____

TELEPHONE: H: _____ W/OFF.: _____ D.O.B.: _____ Age: _____

HIGHEST GRADE/DEGREE: _____ REFERRAL BY:_____

PERSON AND TEL. NO. TO CALL IN EMERGENCY: _____

MARITAL STATUS: _____ FORMER/PRESENT MARRIAGE(S) (years): _____

SPOUSE NAME: _____ AGE: _____ OCCUPATION: _____

CHILDREN/STEP/GRAND (names/ages): _____

OCCUPATION/POSITION: _____

PRESENTING PROBLEM(S): _____

PAST/PRESENT MEDICAL CARE (Specify: major problems, accidents, hospitalizations,

current medication): _____

PAST/PRESENT COUNSELING/PSYCHOTHERAPY/MENTAL HOSPITALS:

1. Therapist: _____ Dates: _____ to _____

Initial reason: _____ Outcome: _____

2. Therapist: _____ Dates: _____ to _____

Initial reason: _____ Outcome: _____

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (any addiction, AA/NA, etc.):
_____

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, VIOLENCE, SUICIDE:
_____

HOW DID YOU HEAR ABOUT US:
_____

Use the remaining space of this page if you need to give further information.