Sonja Glad, MA, DPsS, LCPC

Licensed Clinical Professional Counselor
901 S. Second St. Suite 100
Springfield, IL 62704
(217) 720-5981

Date: ____________

Intake Information

Full Name:_______________________________________ SS#______________________
Address:_______________________________City:_______________State:_____Zip:________
Primary Phone #:_______________Work Phone#:________________Other#:_______________
Date of Birth:___________ Age:________ Relationship Status:________________________
Your Occupation:____________________________Employer:__________________________
Spouse/Significant Other:_____________________ Age:______ Phone #:________________
Occupation:_______________________________ Employer:__________________________
Emergency Contact:___________________________________Phone#:__________________

Children's Names	Bio, Step or Adopted	Date of Birth	Reside in your home?
______________________	________________	__________	yes no sometimes
______________________	________________	__________	yes no sometimes
______________________	________________	__________	yes no sometimes

Doctor's Name & Phone #:____
Approximate Date of Last Physical Exam:____
How Would You Describe Your Physical Health?_____________________________________
Please List All Prescription and Non-Prescription Medicines and Vitamins You Currently Take: _
____
____
Allergies:____
Serious Accidents, Illness or Surgeries:____
____
Alcohol/Drug Habits:____
Exercise Habits:____
Hobbies:____
Please List Previous Therapy (name and dates):_________________________________
Please List Dates of Mental Health Hospitalizations:______________________________
Please List Goals You Would Like to Accomplish in Therapy: 1)_______________________
2)____
3)____

Whom May We Thank For Referring You:____