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Intake Form for Co-Parent Counseling

Name:_____ Date:_____

Address:_____ DOB:_____

City:_____ Zip:_____

Home Phone: _____ Work Phone:_____

Cell Phone: _____ Employer: _____

Married ____ Single ____ Divorced ____, for how long? _____

Attorney: _____ Phone: _____

Referred by: _____

Insurance Billing: _____ Yes _____ No

Previous psychotherapy? _____ Yes _____ No

When? _____With whom? _____

_____

Signature Date

_____

Therapist Date

Names of the Children and their ages:

_____

_____

_____