Christy Shea, MA, MFT

Client Intake Form

(Children and Adolescents**)**

_____ _____ _____

Last Name Middle Initial First Name

_____ _____ _____ _____

Date of Birth Age Grade Gender (Male/Female)

Primary Address

_____ _____ _____

City State Zip Code

Secondary Address if applicable

_____ _____ _____

City State Zip Code

Mailing Address (Same as above)

_____ _____ _____

City State Zip Code

_____ _____ _____

Primary Home Phone Secondary Home Phone Cell Phone

_____

Parent's marital status (Married, Remarried, Single parent, Widow(er), Divorced, Separated

_____

Reason(s) for services

_____

_____

_____ _____

Referral Source May I contact Referral