Christy Shea, MA, MFT
1008 Fifth Street
Santa Rosa, CA. 95404

Client Intake Form
(Children and Adolescents)

Last Name _____ Middle Initial _____ First Name _____

Date of Birth _____ Age _____ Grade _____ Gender (M/F) _____ Email (parents) _____

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 _____