Asmaa Cober Counseling Services

Counseling Intake Form

Name: _____

Address: _____

Phone number: _____

May I leave a message? Yes No

Email if desired:_____

Date of Birth: _____

Marital or relationship Status: _____

Employment status:_____

Number of Children if applicable: _____

Medication/Health Concerns: _____

_____

_____

_____

_____

Family medical history:_____

_____

_____

Spiritual or religious beliefs:_____

Have you received counseling services before? Yes No

Please describe your eating habits:_____

Please describe your sleeping habits:_____

Please describe your exercise or self care habits:_____

Do you use any recreational drugs? Yes no

Do you use alcohol or tobacco? Yes no

What would you like to achieve through counseling?_____