STANDARD INTAKE FORM

Royce Calhoun, Ph.D.
Counseling and Psychotherapy Services
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First MI Last Your Name	Gender: Male ☐ Female ☐	Today's Date: ___/___/___
Home Address	Home Phone # ( ) **Cell Phone #** ( )	
City State Zip	Date of Birth	Age
Employer	Occupation	
Business Address	Business Phone # ( )	
City State Zip	**Email:**	
Relational status: ☐Single ☐Married ☐Committed Relationship ☐Separated ☐Divorced ☐Widowed		
Number of persons other than yourself living in your household?	Adults: _____ Children: _____	

Name of Partner/ Spouse First MI Last	Date of Birth	Age
Employer	Occupation	
Business Address	Business Phone # ( )	
City State Zip		

Children (minor and adult)	Sex	Age	Descriptive Comment

Have you experienced any major changes or events in your life during the past year? Y ☐ N ☐
Have you lost a friend, family member or other significant person during the past year? Y ☐ N ☐
Are you presently seeing another counselor? Y ☐ N ☐ If yes, who?
Have you had previous counseling or psychotherapy? Y ☐ N ☐ Where?
Why are you presently seeking counseling?

Please continue on reverse

Physician: Phone #

Are there any health conditions Dr. Calhoun should be aware of? Y ☐ N ☐ If yes, please describe.

Are you currently taking any medications? Y ☐ N ☐ If yes, please list and give the reason.

How important is spirituality to you in addressing the concerns that brought you to counseling?

Are you active in a church or other spiritual community? If yes, which?

Dr. Calhoun wishes to acknowledge and thank members of the professional community for their trust in referring persons to him for counseling. Your signature below gives him permission to make such contact by telephone, email, or personal letter.

Name of Referring Individual:_____

Street Address:_____ City _____ Zip _____

Your Signature: _____

CANCELLATION AND RETURNED CHECK POLICIES

Dr. Calhoun charges for sessions canceled with less than 24 hours notice.

There will be a $25 charge for each returned NSF check.

I have read and understand these policies.

Signed: _____

Date: _____

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