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## Patient Intake Form

Name \_\_\_\_\_

Home Address \_\_\_\_\_

Telephone Number \_\_\_\_\_

### Marital Status

Married/Living as Married  Separated  Divorced  Widowed  Single

### Family Composition

Household Size \_\_\_\_\_

Number of Children \_\_\_\_\_

Highest Grade Completed \_\_\_\_\_

Employment Status:  Full-time  Part-time  Student  Unemployed  Never Employed

### Primary Presenting Problem

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Alcohol Abuse   | <input type="checkbox"/> Anxiety                 | <input type="checkbox"/> Daily Living Problems       |
| <input type="checkbox"/> Depression      | <input type="checkbox"/> Drug Abuse              | <input type="checkbox"/> Family                      |
| <input type="checkbox"/> Economic Stress | <input type="checkbox"/> Anger/Stress Management | <input type="checkbox"/> Marital/Family Problems     |
| <input type="checkbox"/> Grief/Loss      | <input type="checkbox"/> Medical issues          | <input type="checkbox"/> Cancer Survivors/Caretakers |
| <input type="checkbox"/> Self-Esteem     | <input type="checkbox"/> Life Transitions        | <input type="checkbox"/> Other                       |

Physicians Name \_\_\_\_\_

Physicians Phone Number \_\_\_\_\_

Current Medication(s) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_