INTAKE FORM

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Please fill in the information requested in the spaces provided. This, and all other information relating to your association with us is regarded as strictly confidential and will not be shared with anyone without your signed consent.

NAME:_____DATE:_____

ADDRESS:_____

CITY_____STATE____ZIP_____

PHONE:_____SEX___BIRTHDATE___/___/___AGE_____

MARITAL STATUS: ( )Married ( ) Single ( ) Divorced ( ) Other_____

EMAIL ADDRESS:_____

EMPLOYER:_____WK PH_____

ADDRESS:_____

CITY:_____STATE____ZIP_____

SSN:_____POSITION:_____

SPOUSE'S NAME / OCCUPATION:_____

WITH WHOM DO YOU RESIDE?_____

PREVIOUS COUNSELING?_____

REFERRED TO ACTION ASSOCIATES BY:_____

WHAT MEDICATIONS, PRESCRIPTION OR DRUGS ARE YOU CURRENTLY TAKING?_____

IN CASE OF EMERGENCY NOTIFY:_____

ADDRESS:_____CITY_____ST___ZIP_____

PH NO:_____RELATIONSHIP_____