ALICEN L. HALQUIST, MA, LPC, SEP

INTAKE FORM

Date			Referred By:		
Last Name			First		Initial
Address		City		State, ZIP	
Home Phone	Contact? Y N	Business	Contact? Y N	Cell	Contact? Y N
Fax	Contact? Y N	E-Mail	Contact? Y N	Calling Restrictions	
Social Security Number		Date of Birth		Age	
Employer and Occupation					
❍ Married ❍ Single ❍ Divorced ❍ Widow	Spouse	Child(s) Name/Age			
Physician(s) 1.		2.		3.	
Medical Problems					
Previous Psychotherapy Experience					
Insurance Company			Insurance Adjuster		
Address			City, State, ZIP		
Phone		Name of Insured		Insured's Social Security Number	
Employer		Group Number		Identification Number	

Provide brief answers to the following questions:

1. Your relationship with your family members (i.e. parents, spouse, siblings, children, etc.)?

2. What are your current areas of concern?

3. What are the outcomes you would like to achieve from this treatment?

(303) 517-5430 alicenrule@aol.com www.alicenhalquist.com

4. What is your career history?

5. What is your relationship history?

6. Are you in a relationship now? If yes, is the relationship fulfilling?

7. What is you support system (family, friends, community)? Do you feel supported by each?

8. What people have been important resources to you?

9. What are your strengths, capacities and inner qualities you feel you can rely on?

10. What are your limitations?

11. What events have been significant in your life?

12. What do you know about your earliest life experiences, in-utero, birth and early attachment?

13. Provide any additional information you feel would be helpful for Alicen to know.