PSYCHOLOGICAL SERVICES CLINIC
UNIVERSITY OF NORTHERN COLORADO

Family and Couples Therapy
Client Intake Information

Date: _____

Family Name(s): _____

Address 1: _____

Address 2: _____

Home Phone: _____ Work Phone: _____

Reasons for seeking counseling at this time: _____

_____

_____

Family Members

Initials	Relationship	Age	Date of Birth	Gender	Education	UNC Student (Yes or No)	Sexual Orientation	Race/ Ethnicity

Significant health related issues and medication

Family Member	Health Issue	Duration	Medication	Disability