

STANDARD INTAKE FORM
Royce Calhoun, Ph.D.
Counseling and Psychotherapy Services
4230 Gardendale, Suite 502 San Antonio, TX 78229
rcalhoun@roycecalhoun.com 210-593-9725 Fax 210-593-9714

Your Name	First	MI	Last	Gender: Male <input type="radio"/>	Female <input type="radio"/>	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: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Committed Relationship <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed						
Number of persons other than yourself living in your household?				Adults: _____ Children: _____		

Name of Partner/ Spouse			Date of Birth	Age
First	MI	Last		
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 <input type="checkbox"/> N <input type="checkbox"/>
Have you lost a friend, family member or other significant person during the past year? Y <input type="checkbox"/> N <input type="checkbox"/>
Are you presently seeing another counselor? Y <input type="checkbox"/> N <input type="checkbox"/> If yes, who?
Have you had previous counseling or psychotherapy? Y <input type="checkbox"/> N <input type="checkbox"/> 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: _____

intake form.odt