

*Licensed Psychologist*  
Isles Therapy Center, PLLC  
615 West 35<sup>th</sup> Street  
Minneapolis, MN 55408

**CLIENT INTAKE INFORMATION**

Date \_\_\_\_\_ Referred By \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_ Emergency # \_\_\_\_\_

Procedures for leaving messages \_\_\_\_\_

Email Address \_\_\_\_\_

Name/Address of Employer \_\_\_\_\_

Name of other adult(s) living in household and their relationship to you \_\_\_\_\_

Name/Age of Children Name	Age	(Living at Home)	Y/N
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Presenting Problem \_\_\_\_\_

Previous Therapy Experience \_\_\_\_\_

Initial Therapy Services Requested: Individual \_\_\_\_\_ Couple \_\_\_\_\_ Family \_\_\_\_\_ Group \_\_\_\_\_ Other \_\_\_\_\_

- \_\_\_\_\_ I give my permission for Sandra to contact my referral source to let them know we have met.
- \_\_\_\_\_ I give my permission for Sandra to mail follow-up letters, surveys, and/or related informational materials after we have completed our services.
- \_\_\_\_\_ I give my permission for Sandra to contact my insurance carrier for information related to coverage of services.

I certify with my signature below that the information above is correct to the best of my knowledge.

\_\_\_\_\_  
Client Signature