DOORS OF HOPE COUNSELING
8575 w. 110th St. Suite 218
Overland Park, KS 66210
913-712-4412
counseling@doorsofkc.com

CONFIDENTIAL INTAKE FORM

Date _____ **Therapist Name** _____

CLIENT'S INFORMATION

Client's Name_____ Marital Status (circle one): S M W D Sep

Date of Birth: _____ Sex ___ SS# _____

Address:_____ City, St., Zip _____

List an **approved number** to contact or leave a message:

Cell #_____ Home #_____ Business # _____

Client's Employer _____ Occupation _____

Employer Address, City, St., Zip _____

Please Specify Person Responsible For Payment: _____

Referred By _____

Briefly describe the problem _____
_____

IF THE CLIENT IS A MINOR

Father's name _____Date of Birth_____

Address, City, St., Zip _____

Cell Number _____ Home Number _____ Business Number _____

Father's Employer _____Occupation _____

Employer's Address _____ City, St., Zip _____

Mother's name_____ Date of Birth _____

Address, City, St., Zip _____

Cell Number _____ Home Number _____ Business Number _____

Mother's Employer _____ Occupation _____

Employer's Address _____ City, St., Zip _____