Spring Tree Counseling

Emotional, Relational, and Mental Well-Being

Adult Intake Form

Demographic Information

Full Name: ____ DOB:________________

Last First M.I.

Address: ____

Street Address Apartment/Unit #

____

City State ZIP Code

Phone: ______________________________ Email: ____________________________________

Okay to leave voicemail message? YES NO

Gender (if using insurance): MALE FEMALE

Medication: ____

Referral Source: ____

Family Information

Marital Status: ____________________ Years Married: __________

Partners name (*couples therapy only*): ________________________________DOB:_________

Child: ______________________Age:___________ Child: __________________ Age:______________________

Child: ______________________Age:___________ Child:__________________ Age:______________________

Payment Information

Please select a method of payment.

Cash or Check

Zelle® Quickpay

Send payments to: Admin@springtreecounseling.com

Credit or Debit Card (HSA/FSA accepted):

Card number: ______________________________________ Exp Date: ____________________

Billing address (if different):