Welsh Wellness and Counseling, LLC

11426 York Rd.|1st floor |Cockeysville, MD| 21030
Erin Welsh, LCPC

Client Intake Information

Client Name: _____ DOB: _____ Date of Intake:_____
Guardian's Name/Relationship:_____
Address: _____ City: _____ Zip: _____
Numbers we may contact you to protect your confidentiality : Cell: _____
Work: _____ Home: _____ Best time to call: _____

Email Address: My therapist has permission to contact me by email to schedule appointments or to share helpful information that may be of interest to me. Yes _____ No _____
Email Address: _____

Emergency Contact: Name _____ Relationship _____
Phone: _____
Where did you hear of our office?_____
Why are you seeking help at this time?

_____
Physician name: _____ Phone: _____
Date of last exam:_____ Medications: _____
Current Health Issues: _____
Psychiatrist:_____
List names and ages of family members living with you:

_____
_____

Circle any of the concerns/problems below if they pertain to you:

anxiety	eating disorder	memory loss	sleep problems
depression	family violence	academic issues	appetite
alcohol Use	fears	anger/Conflicts	stress
drug use	obsessive/compulsive	loneliness	self-control
focusing	opposition	organization	social issues

Signature of responsible party:

_____