

Hilltop Counseling Services  
Intake Information

Application for Admission

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

\_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_

\_\_\_\_\_ SS#: \_\_\_\_\_

Marital Status: \_\_\_\_\_ 1st 2nd 3rd 4th Widowed Divorced

# of Dependents \_\_\_\_\_ Ages: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Phone #: \_\_\_\_\_

Shift: 1st 2nd 3rd Swing Unemployed Disabled

Emergency Contact Person: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Referral Source (check one) \_\_\_\_\_ word of mouth \_\_\_\_\_ yellow pages

\_\_\_\_\_ court order \_\_\_\_\_ other \_\_\_\_\_

Brief Statement of Problem: \_\_\_\_\_

Previous Counseling/Therapies:

\_\_\_\_\_

Current Counseling/Therapy: \_\_\_\_\_

\_\_\_\_\_

Are you currently under a doctor's care: If yes, explain:

\_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Current Medications:

\_\_\_\_\_

Last Doctor's Visit: \_\_\_\_\_ Dentist: \_\_\_\_\_