Felix Scardino, LCSW
Individual, Couple and Family Counseling

INTAKE FORM
1801 Lexington
Houston, Texas 77098

(Please Print) Date _____

CLIENT	EMPLOYMENT
Name _____	Occupation _____
Address _____	Business Name _____
City _____ State _____ Zip _____	Position Held _____
Telephone (_____) _____	Length of Time Employed _____
Birthdate _____ SS# _____	Telephone (_____) _____
Level of Education _____	Cell Phone (_____) _____
Birthplace _____ Religion _____	Email _____

SPOUSE	EMPLOYMENT
Name _____	Occupation _____
Address _____	Business Name _____
City _____ State _____ Zip _____	Position Held _____
Telephone (_____) _____	Length of Time Employed _____
Birthdate _____ SS# _____	Telephone (_____) _____
Level of Education _____	Cell Phone (_____) _____
Birthplace _____ Religion _____	Email _____

CHILDREN

Name	Age	Grade Level	Living at Home	From Present or Previous Marriage

MARITAL STATUS

Single Married Separated Divorced Widowed Date of Status _____

List Previous Marriages: (Date: From-To)

_____

_____

_____

Do you have any significant physical health problems/complications? Yes No If yes, please explain

_____

Do you use any medication? Explain _____

_____

Have you been in psychotherapy before? Explain _____

_____

Who referred you for counseling? _____

In case of an emergency someone we may contact who is not a member of your immediate household.

Name _____ Telephone (_____) _____ Cell Phone (_____) _____

FAMILY DIAGNOSTIC INVENTORY: (Please Circle the Appropriate Number)

Areas of Concern	Very Dissatisfied									To Very Satisfied
Social Activities	1	2	3	4	5	6	7	8	9	10
Money Matters	1	2	3	4	5	6	7	8	9	10
Sexual Experience	1	2	3	4	5	6	7	8	9	10
Career/Job	1	2	3	4	5	6	7	8	9	10
Religion	1	2	3	4	5	6	7	8	9	10
Talking Communication	1	2	3	4	5	6	7	8	9	10
Household Chores/Responsibilities	1	2	3	4	5	6	7	8	9	10
Decision Making Progress	1	2	3	4	5	6	7	8	9	10
Alcohol/Drugs	1	2	3	4	5	6	7	8	9	10
Health/Medicine/Drugs	1	2	3	4	5	6	7	8	9	10
My Independence	1	2	3	4	5	6	7	8	9	10
Rearing/Discipline of Children	1	2	3	4	5	6	7	8	9	10
Marital/Family Goals and Values	1	2	3	4	5	6	7	8	9	10
Relatives/In-Laws	1	2	3	4	5	6	7	8	9	10
Spouse's Independence	1	2	3	4	5	6	7	8	9	10
Leisure Time/Hobbies	1	2	3	4	5	6	7	8	9	10
Vacations	1	2	3	4	5	6	7	8	9	10
Food - Shopping, Cooking, Eating Out	1	2	3	4	5	6	7	8	9	10
Emotional Closeness	1	2	3	4	5	6	7	8	9	10
General Marital Satisfaction	1	2	3	4	5	6	7	8	9	10

CENTER POLICIES

You will be charged for cancelled appointments unless notice is received at least 24 hours prior to the appointment time so that the time may be scheduled for another client.

We request that you pay at the time of each visit.

If using insurance complete the insurance form provided.

You will receive a monthly statement for your records.

There will be a charge for phone consultations exceeding 15 minutes.

I understand and accept the policies concerning cancellation of appointments, billings, insurance statements and phone consultations. I will be responsible for payment.

Therapist

Client