Geriatric Counseling Intake
West Suburban Senior Services
A Council on Aging

Date:

Name *(Last, First, M.I.):* **M F DOB:**

Address

Street & Number

City, State & Zip

Home Phone May we leave a message No Yes

Cell/other Phone May we leave a message No Yes

email: May we email you No Yes

*Please note:email correspondence is not considered to be a confidential medium of communication.

General Information

Marital status: (circle one) • Single • Partnered • Married • Separated • Divorced • Widowed Civil Union

Name of legal guardian *(Last, First, M.I.):*

Are you a Vet: No Yes **Homebound:** No Yes **Transportation Needs.**

African American Hispanic Asian/Pacific Islander Native American Caucasian

Primary Language: **Secondary Language:**

Have you received any type of mental health sevices (psychotherapy, psychiatric services? No Yes

If Yes, previous therapist/practioner Name and #

Primary Physician Name & Number Date of last Physical

Referral Source: Relationship: Phone #

How did you hear of our services?

Emergency Contacts Name & Phone

1

2

3

Social Support

Contact Log

Initial Contact Received Entered

Called

Appointment:

Please bring a list of Medicine.

Reason for coming