The Counseling Team International
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ADMISSION FORM

Case #:_____ **Therapist Name:**_____

Intake Date: _____

Client Name: _____ **Client Gender: M F DOB:** _____

Address:_____ **Relationship: if not employee** _____

_____

Contact Phone: _____ **Marital Status:** ☐ **Married** ☐ **Single** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**

Employee Name: _____

Current Address (If different) _____

_____

Phone: _____ DOB: _____

Division: _____

Employment City: _____

EMPLOYEE JOB CLASSIFICATION:

___ Agent/Pilot
___ Technical/Clerical
___ Professional/Admin.
___ Diversion Investigator
___ Chemist
___ Intelligence Res. Spec.

GS LEVEL: 1-5 _____
6-10_____
11-15_____

Education Level_____
Years of Service: _____

Type of Problem ***(check one only)***	✓	***Symptom Description***
Emotional		
Relationship/Family		
Occupational		
Substance Abuse		
Phase of Life Problems		

PROBLEM STATEMENT:

_____

_____

_____

_____

TREATMENT PLAN/GOALS:

_____

_____

_____

_____