



# Intake Form

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Lizanne Corbit, MA, LPC, NCC  
Licensed Professional Counselor

Date: \_\_\_\_\_ Referred by: \_\_\_\_\_

Name: \_\_\_\_\_ Phone (h): \_\_\_\_\_

(o): \_\_\_\_\_

(m): \_\_\_\_\_

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

Email: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Brief description of current problem or reason for seeking counseling or coaching:

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

Health Problems (if any): \_\_\_\_\_

Current Medications: \_\_\_\_\_

Occupation: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Previous Marriages: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Dates of Marriage(s): \_\_\_\_\_

Names and Ages of Child(ren) or Pets: \_\_\_\_\_

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