



THE PRIVATE PRACTICES OF

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Adult Intake Form

Name: _____ Date: _____
First Initial Last Nick

Referred by whom: _____ Phone: _____

SS #: _____ Age: _____ DOB: _____

Street Address: _____ City _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Personal Email: _____

Employer: _____ Job Title: _____ Education: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Spouse/Partner: _____
Name Date of Birth Employer Work Phone

Assessment of Relationship: Good ___ Fair ___ Poor ___ Children (ages): _____

Reason for seeking services/stressors/Goals/Expectations: _____

Current/Previous Mental Health Diagnosis: _____

Previous Therapist(s) Phone # Date(s) of Treatment

Physician: _____

Name Phone Address

Assessment of Current Health: Good ___ Fair ___ Poor ___ Allergies: _____

Health Issues: _____

Current Medication(s) Dosages Prescribing Physician

Previous Hospitalizations/In-Patient facility Date Admission Reason

