

**Kathy Leary-Wilde, MA, LMFT**  
**Licensed Marriage and Family Therapist, 47685**

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**Intake Information**

Client \_\_\_\_\_ Date \_\_\_\_\_

Birthdate \_\_\_\_\_ Cell \_\_\_\_\_ Landline \_\_\_\_\_

Email \_\_\_\_\_

Best way to contact you \_\_\_\_\_

Address \_\_\_\_\_

Employer, school \_\_\_\_\_

Who referred you? \_\_\_\_\_ Previous therapy? \_\_\_\_\_

Date of last physical \_\_\_\_\_ Major illnesses \_\_\_\_\_

Current medications \_\_\_\_\_

**Family members:**

| Name  | Relationship | DOB   | Phone |
|-------|--------------|-------|-------|
| _____ | _____        | _____ | _____ |
| _____ | _____        | _____ | _____ |
| _____ | _____        | _____ | _____ |
| _____ | _____        | _____ | _____ |

Person responsible for account \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_