



**TPC**  
Integrative Psychotherapy  
& Pastoral Counseling

Web tripastoralcounseling.org  
Phone 919.845.9977  
Fax 919.845.9761

**Client Intake Information**

First Session: \_\_\_\_\_ Therapist: \_\_\_\_\_ Client ID: \_\_\_\_\_

Client Name \_\_\_\_\_ DOB (mm/dd/yyyy) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Phone/E-mail** (Please list any phone number or e-mail addresses we may use to contact you)

May we leave a message?  Yes  No

\_\_\_\_\_  Home  Mobile  Work  Other  
Phone Number

\_\_\_\_\_  Home  Mobile  Work  Other  
Phone Number

\_\_\_\_\_ E-mail Address

Emergency Contact Person \_\_\_\_\_ Relationship to Client \_\_\_\_\_ Phone Number(s) \_\_\_\_\_

**Referral Source:**  Clergy  Former Client  Friend  Mental Health Agency  Physician  
 Educator  Website  Psychology Today  Insurance Co.  Other: \_\_\_\_\_

Referral Name: \_\_\_\_\_

Permission to write a thank-you note to Referral Source (please initial): Yes \_\_\_\_\_ No \_\_\_\_\_

*I certify the above information is accurate:*

Signature of Client (or Guardian) \_\_\_\_\_ Date \_\_\_\_\_