

Joe Borders, LMFT
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Sacramento, Ca 95825 Roseville, Ca 95661
Joe Borders, LMFT –New Client Intake-

Date _____ How were you referred? _____

Name	Date of Birth	Age
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Name of Significant Other	Date of Birth	Age
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Street Address	City	Zip Code
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Telephone: Home _____ Work _____ Cell _____

Emergency Contact: Name _____ Phone # _____

Children:

Name _____ Age _____	Name _____ Age _____
Name _____ Age _____	Name _____ Age _____

Siblings:

Name _____ Age _____	Name _____ Age _____
Name _____ Age _____	Name _____ Age _____

Primary Care Physician _____

List any medications you are currently taking and any major health concerns and/or chronic conditions. _____

Previous counseling? Yes___ No___ Dates & Reason: _____

Briefly explain your need for counseling/therapy at this time

Signature _____

Signature _____