Northern Virginia Older Adult Counseling
Client Intake Form

REGISTRATION

NAME: _____ Marital Status: M W D S

ADDRESS: _____

HOME PHONE #:_____CELL PHONE #:_____

EMAIL: _____

DATE OF BIRTH: _____

EMERGENCY CONTACT INFORMATION

PRIMARY CONTACT: _____

SECONDARY CONTACT(S): _____

MEDICAL INSURANCE:

Primary _____ID#_____

Secondary_____ID#_____

ADVANCE DIRECTIVES: YES_____ NO_____

POWER OF ATTORNEY FOR HEALTH CARE: _____

GENERAL DURABLE POWER OF ATTORNEY: _____

ARE YOU A VETERAN OR SPOUSE OF A VETERAN? _____

MEDICAL

CURRENT MEDICAL CONDITIONS: _____

_____

CURRENT MEDICATIONS: _____

_____

RECENT HOSPITALIZATION/SKILLED REHAB: _____

EMOTIONAL

DEPRESSION? _____ ANXIETY? _____FAMILY CONCERNS? _____COGNITIVE? _____

BEREAVEMENT/GRIEF? _____ OTHER CONCERNS? _____

SOCIAL

SIGNIFICANT FAMILY MEMBERS/FRIENDS: _____

_____

OCCUPATION/INTERESTS/HOBBIES: _____

_____

SPIRITUAL

FAITH ORIENTATION/SPIRITUAL INTERESTS: _____

_____