

# ALISHA WOODALL, LPC #62271



14275 Midway Rd.  
Addison, Tx 75001

## INTAKE FORM

*Please fill out as completely as possible and bring with you to our first session. It will help me in our work together. If you do not desire to answer any question, simply write "Do not care to answer" in the provided space.*

**NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**BIRTHDATE:** \_\_\_\_\_ **AGE:** \_\_\_\_\_

**SSN #:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_  
\_\_\_\_\_

**Insurance Provider:** \_\_\_\_\_ **ID#** \_\_\_\_\_

**CONTACT: (Circle which time of day for each #)**

**Home :**(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Am/Pm**

**Office :**(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Am/Pm**

**Cell: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Am/Pm****

**E-MAIL:** \_\_\_\_\_

**Briefly describe your reason for today's visit:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Estimate the severity of the above issue:**

Mild  Moderate  Severe  Very severe

How did you hear about Alisha Woodall, LPC? \_\_\_\_\_

**CURRENT: Marital status:**

Married  Divorced  Live with someone  Single

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

Years: \_\_\_\_\_

**MEDICAL DOCTOR(S):**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

**PAST/PRESENT MEDICAL ISSUES:**

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**Specify all MEDICATION you are currently taking and for what:**

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**History of Substance Abuse: (include names of drugs and if applicable, treatment history)**

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**History of Suicide Attempts: (include dates, details of attempt, and treatment)**

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**FAMILY MEDICAL HISTORY (Describe any illness that runs in the family)**

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