



Loretta Parker, LMFT
Reconnection Family Counseling Services
INTAKE FORM

Name: _____ Date: _____

Address: _____ DOB: _____

City: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Employer: _____

Email: _____

Married ____ Single ____ Divorced ____ Widow/er ____

In Case of Emergency Call: _____

Relationship: _____ Phone _____

Referred by: _____

Attorney Name:

Attorney Phone Number:



4221 Northgate Blvd., Suite 5, Sacramento, CA 95834
916-674-0144
www.lovinglifefamilytherapy.com



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Child(ren) Name(s):

Name	DOB	Grade in School
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Name	DOB	Grade in School
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Name	DOB	Grade in School
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Name	DOB	Grade in School
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1. Describe your relationship with each of the children:



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2. Describe a history of your relationship with the other parent:

3. Describe your goals for counseling:

4. Describe your concerns for counseling:



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5. How would you want to grow personally in this process?

6. What do you think will be the most significant challenges to achieve the stated goals?



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