KENYA COUNSELLING AND PSYCHOLOGICAL ASSOCIATION
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CLIENT INTAKE FORM

Name of client……Age……Sex……..…Nationality……...

P.O. Box ……..…….Code……Town……..County: …….…….

Office Address……Contact:…….. Email……

Marital status: Single [ ] Married [ ] Widow [ ] Widower [ ]. Other [ ] S*pecify*…….

Occupation…….

Issues of concern…….

Referral source…….....

Has the client been previously counselled? Yes [ ] No [ ]

If so by whom……..…Where……..……..

Currently on medication? Yes [ ] No [ ]. If Yes, who is the Doctor? .....

Any Alcohol/Drug usage? Yes [ ] No. [ ]. ……

Time/date client is available for counselling.....……. Client sign……

Name of interviewer……Date……..…….Sign……

Name of Counsellor……..Date……...Sign……

Client No …….

BILLING INFORMATION (*office use only*)

Client Name……Client No…….…..

Address……Phone No…….….

Home……...Office ……..….

Name of Counsellor assigned……..Counsellor No……..…

Date counselling begins……Intake fees (ksh)…… Charges per session (ksh)……....

Payment intervals: Weekly [ ] Monthly [ ]

Date Client referred out …… Referred to: …….

Reason for referral ……...

Date counselling ended……..Counselor's name/sign…….