STANDARD INTAKE FORM

Randall R. Lyle, Ph.D., LMFT, BCIA-EEG
1120 2nd Ave. SE
Cedar Rapids, IA 52403
319-261-2291 Office, 319-538-0196 Fax

First MI Last Client's Name	Gender: Male ☐ Female ☐	Today's Date: ___/___/___
Home Address	Home Phone # ( ) Cell Phone # ( ) Email __________________________________ O.K. to send email? _____yes ______no	
City State Zip	Date of Birth	Age
Employer	Occupation	
Business Address	Business Phone # ( )	
City State Zip	Social Security #	
Relational status: ☐Single ☐M		☐C
Number of persons other than yourself living in your household?	Adults: ___________	Children: __________

Name of Partner/ Spouse/ Parent First MI Last	Date of Birth	Age
Employer	Occupation	
Business Address	Business Phone # ( ) Cell Phone # ( )	
City State Zip		

Children (minor and adult)	Sex	Age	Descriptive Comment

Have you experienced any major changes or events in your life during the past year? Y ☐ N ☐
Have you lost a friend, family member or other significant person during the past year? Y ☐ N ☐
Are you presently seeing another counselor? Y ☐ N ☐ If yes, who?
Have you had previous counseling or psychotherapy? Y ☐ N ☐ Where?
Please Continue on the Reverse

What brings you to therapy?

Physician: Phone #

Are there any health conditions I should be aware of? Y ☐ N ☐ If yes, please describe.

Are you currently taking any medications? Y ☐ N ☐ If yes, please list and give the reason.

How important is spirituality to you in addressing the concerns that brought you to counseling?

Are you active in a church or other spiritual community? If yes, which?

Dr. Lyle wishes to acknowledge and thank members of the professional community for their trust in referring persons to him for counseling. Your signature below gives him permission to make such contact by phone or letter.

Name of Referring Individual:____

Street Address:____________________________ City ___________________ Zip _______

Your Signature: ______________________________________

CANCELLATION AND RETURNED CHECK POLICIES

Dr. Lyle charges for sessions canceled with less than 24 hours notice.

There will be a $25 charge for each returned check or “do not honor” credit card payment.

I have read and understand these policies.

Signed: ________________________________

Date: ________________________________