

**In-Joy Therapy and Yoga  
Client Intake Form**

Name(s): \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

How were you referred to In-Joy? \_\_\_\_\_

\_\_\_\_\_

**Contact Information:**

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Best way to reach you? \_\_\_\_\_

**Occupation and Employer:**

\_\_\_\_\_

**Background Information:**

Date of Birth (if a family, provide each member's birth date):

\_\_\_\_\_

Relational Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Cohabiting \_\_\_\_\_

Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

Name of Partner/Spouse: \_\_\_\_\_

Comments: \_\_\_\_\_

Names and ages of children, if any:

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Have you been in counseling before? Yes \_\_\_\_\_ [If yes, when? \_\_\_\_\_] No \_\_\_\_\_

Are you currently taking medication? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, name and dosage: \_\_\_\_\_

If yes, who is monitoring your medication? \_\_\_\_\_

Would you be willing for In-Joy to collaborate with them? Yes \_\_\_\_\_ No \_\_\_\_\_

[If yes, please sign and date the collaboration consent form]

Are you under any holistic care (i.e. massage, acupuncture, etc.) \_\_\_\_\_

If child is in treatment:

Adopted \_\_\_\_\_ Birthed \_\_\_\_\_

If adopted, please explain (domestic, international, open/closed):

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Pertinent information about the child's birth, if any:

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**In Case of Emergency**

Name and contact information: \_\_\_\_\_

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Relationship to you: \_\_\_\_\_

Do they know you are seeking therapy? \_\_\_\_\_

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**Return the completed and signed form to:**

Sharon Hyman, LCSW-C, RYT

In-Joy Therapy and Yoga

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