

# INTAKE FORM

Date \_\_\_\_\_ SS# \_\_\_\_\_

Client Name \_\_\_\_\_

Home phone \_\_\_\_\_

Spouse/Parent/Guardian Name \_\_\_\_\_

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

Address \_\_\_\_\_

Cell phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

\*Please check box if O.K. to leave message

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Date of birth \_\_\_\_\_

Age \_\_\_\_\_

Sex Male  Female

Race \_\_\_\_\_

Education completed \_\_\_\_\_

Marital Status:

Single

Emergency Contact: \_\_\_\_\_

Married

Separated

Emergency Contact's Phone: \_\_\_\_\_

Divorced

Widowed

Religious affiliation \_\_\_\_\_

Previous counseling: Yes  No  Name of counselor \_\_\_\_\_

What brings you to counseling at this time? \_\_\_\_\_

Primary Physician \_\_\_\_\_ Office Phone \_\_\_\_\_

Current medical conditions \_\_\_\_\_

Current medications \_\_\_\_\_

Insurance coverage: Yes  No  Name of company \_\_\_\_\_

Name of insured \_\_\_\_\_ ID# \_\_\_\_\_

Name of insured's employer \_\_\_\_\_ Insured's date of birth \_\_\_\_\_

Please furnish your insurance card so we may photocopy.

Referred by (**use code below**) \_\_\_\_\_ Name \_\_\_\_\_

May we thank this referral? Yes  No

**Referral code**

- |                                 |  |                        |
|---------------------------------|--|------------------------|
| 1. Friend/relatives of client   | 5. Publicity (yellow pages, brochures) | 8. Insurance           |
| 2. Former Client                | 6. Seminar conducted by therapist      | 9. Other Professionals |
| 3. Clergy or MAP                | 7. Self Referral                       | 10. Other Agency       |
| 4. Employee Assistance Programs |  |                        |