

Client Intake Information Sheet

Client Information:

Name: Last _____ First _____ Mdl _____ Title: _____

Address: _____ City: _____ State _____ Zip Code _____

Phone: (Home) (____) _____ Work (____) _____ Cell (____) _____

Do you prefer that we use home, work or cell number _____

e-mail address: _____ May we contact you by e-mail? _____

Marital Status: _____ [S-Single, M-Married, W-Widowed, D-Divorced, P-Separated]

Sex: _____ Date of Birth: _____ Age: _____ Social Security # _____ - _____ - _____

Employer: _____ Occupation _____

Who do we call in the event of an emergency? _____ Their Phone # _____

If you are not financially responsible for all professional services rendered to you at the office please inform us what party is responsible by filling in the next section:

Responsible Party: (list either the name of the organization or person who is financially responsible for your account)

Name of Organization: _____

Individual's Name: Last _____ First _____ Mdl _____ Title: _____

Address: _____ City: _____ State _____ Zip Code _____

Phone: (Home) (____) _____ Work (____) _____

Were you referred to our office? _____ If yes, by whom? _____

Primary Care Physician/Medical Information: Do we have permission to contact your physician? _____

Name of your physician: Dr. _____ Telephone #: _____

Clients that provide us with permission to contact their primary care physician will have a brief letter sent to their doctor indicating that contact has been made at our office. Diagnosis information may also be released to the physician. Do we have your permission to contact your physician? Yes: ____ No: ____ . If yes, please sign below indicating you give us permission to inform your doctor of your mental health

therapy. **Client Signature:** X _____ Date: _____

Witness to signature: X _____ Date: _____

Medications you are taking: _____

Are you allergic to any medications: _____ if yes, which medications: _____

Medical conditions you are being treated for currently: _____

Insurance Policy Holder Information: Policy Holder Name: _____ DOB: _____

(Insured's relationship to client: _____) Address: _____

Telephone: _____ Sex: _____ Social Security Number: _____ - _____ - _____ Employer: _____

_____. Primary Insurance Company: _____

Insurance Company Address: _____ Telephone #: (____) _____

Certificate #: _____ Group #: _____

@@@@@@@@@@@@@@@@@@@@@**Office Use Only** @@@@@@@@@@@@@@@@@@@@@@

Counselor _____ Date first seen _____

Will therapist or office send out bills? _____

DSM-IV Diagnosis: Axis I: Code: _____

Axis II: Code: _____