

**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: \_\_\_\_\_