Client Intake Information Sheet

Client Information:

Name: Last_____ First_____ Mdl_____ Title:____

Address:_____City:_____State_____Zip Code_____

Phone: (Home) (___)_____Work (__) _____Do you prefer we use home or work phone?_____

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 #:_____

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Counselor_____ Date first seen_____

Will therapist or office send out bills?_____

DSM-IV Diagnosis: Axis I: Code:_____

Axis II: Code:_____