

Client Intake Form

Client Information	
Name	
Street	
City, ST, ZIP	
Today's Date:	OK to leave msg?
Ph (day)	Y N
Ph (eve)	Y N
Ph (cell)	Y N
DOB	Age
Social Sec #:	
Emergency Contact	

Requested Services (Check all that apply)
<input checked="" type="checkbox"/> Initial Consultation
<input type="checkbox"/> Adjust to Life Change
<input type="checkbox"/> Anxiety, Depression, Stress or Anger
<input type="checkbox"/> Trauma Recovery
<input type="checkbox"/> Couple or Family Counseling
<input type="checkbox"/> Build Self-Esteem & Effectiveness
<input type="checkbox"/> Executive Performance Enhancement
<input type="checkbox"/> Other _____

Physician
Primary
Psychiatrist (if any)
Billing Information
Responsible party (if other than client)
Street
City, ST, ZIP
Ph (day)
Ph (eve)
Insurance Information (BCBS, Medicaid only)
Subscriber
Subscriber ID
Subscriber DOB
Employer
Group
Subscriber SS#
Relation to insured
Referral
How did you hear of us?
If from a person, OK to thank? Y N

I understand I must also read and sign the Psychotherapy Services Agreement and Fee Agreement before services can be given. I understand I am responsible for payment at the time services are rendered.

 Client Name (Print)

 Responsible Party (Print)

 Signature & Date

 Signature and Date