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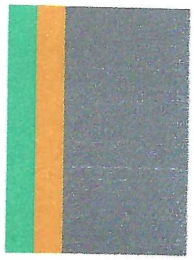

Intake Form:

Today's date: _____
Name: _____
Age: _____ Client's Date of Birth: _____
Address: _____
_____
Phone number
Work: _____
Cell: _____
Email address: _____
OK to leave messages? Where?
Place of Employment: _____
Relationship Status: _____
Name and phone number of emergency contact: _____
_____
Emergency contact Relationship to Client: _____
Private Pay Amt. if not using insurance: _____
Insurance Information:
Name of Insurance Company: _____
Ins. Phone: _____
Subscriber: _____
Name: _____
Address: _____
Date of Birth: _____
Client Relationship to Subscriber: _____
Self ( ) Spouse/Partner ( ) Child ( )
Member ID #- _____
Group# _____
Co-pay/Co-ins. Amt.: _____
Deductible Amount: _____

Primary Care Physician (name/address/phone number): _____

_____

Medical Conditions: _____

_____

What medications/Supplements are you are you taking?

_____

_____

Allergies: _____

_____

Previous counseling: With whom, dates: _____

What do you hope to achieve by counseling now? _____

_____

_____