



Intake Form

Client Name: _____

DOB: _____ Age: _____

Street: _____

Gender: _____

City: _____

SSN: _____

Home Phone: _____

Marital Status: _____

Work Phone: _____

School: _____

Cell Phone: _____

Grade Level: _____

County: _____

Employer Name: _____

Additional Client: _____

Occupation: _____

Parent/Guardian: _____

Denomination: _____

Children: _____

Church: _____

Race: _____

Assigned Provider: _____ Appointment Date: _____ Time: _____

Location: _____

Name of Referral: _____

Would you give permission for the Center to contact the person who referred you? ____yes ____no

Have you had previous counseling? ____yes ____no

If yes, name of counselor: _____ Date: _____

Physician: _____

Please list current medications: _____

Person to contact in case of emergency: _____

Relationship: _____ Phone Number: _____

I certify that the above information is correct and I understand and accept the policies of the attached letter.

Client Signature

Date

Insurance Information

Insurance Company: _____

About the Insured

Street: _____

Name: _____

City: _____

SSN of Insured: _____

Phone: _____

Street (if different from client): _____

Policy Number: _____

City: _____

Group Number: _____

Phone: _____

Policy Effective Date: _____

D.O.B.: _____

Authorization #: _____

Relationship to client: _____