INDIVIDUAL INTAKE FORM

Today's Date_________________ Name____

Address____Date of Birth:___________________

City___________________________ State_______ Zip____________ Gender: M______ F________

Home Phone_______________________________ Work Phone___________________________________

Cell Phone______________________________ Email Address____

Which Phone Number Do You Prefer Messages?______________________Referred by____________________

Married? ☐ Divorced? ☐ Single? ☐ Separated? Name/Ages of Children_______________________

Policy Holder Name & Date of Birth____

Occupation______________________________Employer____

Issues of Concern Today____

What medications are you presently on?____

Any previous counseling? Yes ☐ No ☐ With whom?____

What concerns brought you in to counseling at that time?____

Why did you discontinue?____

In Case of Emergency, you have my permission to contact:____

Phone Number(s):____

I have received, read, and understand the Counseling Agreement and the Notice of Privacy Rights.

1 authorize the release of the minimum amount necessary of my personal health information to Billing Professionals and to the applicable insurance company in order to obtain payment for services received.

Signature____Date____________________________

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