



**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 \_\_\_\_\_