

INTAKE for Psychotherapy

NEW Patient
 RETURNING Patient
 Current Patient; Info Update

<u>PATIENT INFORMATION</u>				
Name (last, first):		F	M	Date:
Social Security #	Patient DOB:	Age:	Minor?	Y N
Home Address:		Home Phone:		
Address Cont		Cell Phone:		
Employer Name:		Work Phone:		
Employer Address:			Occupation:	
Emergency Contact Person:		Relationship to Patient:	Emergency Phone:	
Who referred you?		Physician Name:		Physician Phone:
Marital Status: () Never Married () Married () Divorced () Living Together () Separated () Other				
<u>RESPONSIBLE PARTY- INSURANCE INFORMATION</u>				
Are you the insured? Y N		Policyholder Name:		Relationship to Patient:
Insurance Company:				
Policy Number:		Policyholder SSN		Policyholder DOB:
Group Number:		Policyholder Address:		Policyholder Phone:
Employer:		Address Cont		Other Phone:
Insurance Phone Numbers:				Effective Date of Policy:
Additional Information:				
Name of SECONDARY INSURANCE		Policyholder Name:		
Policy Number:		Policyholder SSN:		
Insurance Phone Number:		Policyholder DOB-.		
Education: () some high school () some college () graduate school () high school graduate or GED () college graduate				

Previous mental health counseling? Yes _____ No _____

If Yes, when? _____

Where _____

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What brings you in today?
