Intake Form

Section I - Client Information **Date:**

Last Name: ____________________________First Name:____________________ MI:______

Sex: ______ Age: _______ Date of Birth:____/____/____ SS#_________-______-_________

Address: ____

City: ____________________________ State:___________ Zip:____________________

Telephone: (Home) ______________________ (Work) _______________________

Current Employer: _________________________ Occupation: ___________________________

Are you covered by: ❑ Williamson Co EAP ❑ Insurance ❑ Self-Pay/Other

Section II – County Employee/Insured Information

Patient Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

Last Name: ____________________________First Name:____________________ MI:______

Sex: ______ Age: _______ Date of Birth:____/____/____ SS#_________-______-_________

Address: ____

____

Telephone: (Home) ______________________ (Work) _______________________

Current Employer: _________________________

Section III - Insurance Policy Information

❑ Medicare ❑ ChampUS ❑ ChampVA ❑ Group Health Plan ❑ FECA ❑ Other

Insurance Company: ____

Billing Address: ____

____

Phone: ____

Plan Name: _______________________ Effective Date: ____________________

Policy No.: _______________________Group No.: _______________________

Section IV - Additional Client Information

Marital Status (Check One): ❑ Single ❑ Engaged ❑ Married ❑ Separated ❑ Divorced

❑ Widowed ❑ Living with someone ❑ Remarried: How many times?_____________

With whom do you live? (Check all that apply): ❑ Self ❑ Parents ❑ Spouse ❑ Roommate

❑ Significant Other ❑ Child(ren) ❑ Friend(s) ❑ Other: _____________________

If you have children, please list names and ages: ____

____

By whom were you referred: ____

Intake Form – Page 2 **Client:** ______________________________

Please provide a brief description of why you are seeking therapy: ______________________________

____

____

____

____

How long have you been struggling with these issues? ______________________________________

Are these issues effecting your performance at work? ____________ If yes, in what ways? __________

____

____

Have you ever been in therapy before? ______ If so, please list the names of therapists and the concerns for which you saw them: ____

____

____

____

When were you last in therapy? From (Date) _____________ To (Date) __________________

Are you currently taking any medication? ______ If yes, please list _______________________

____

____

Do you have any medical conditions, illnesses or disabilities? _________________________________

____

____

Family Physician: Name ____

Address ____

____

Many insurance companies request that I notify your primary care physician about your treatment: please check the appropriate box and sign next to it:

______ Yes, I authorize you to provide treatment information to my physician____________________.

______ No, I do not want any information provided to my physician at this time____________________

Please identify in the space provided below a person we should contact in case of an emergency:

Name ____ Phone ________________________

Relation of Contact Person _________________________________