INTAKE FORM

Name: _____ Date of Birth: _____

Address: _____
Home Telephone #: _____ Cell #: _____Work #

Name of Employer: _____

Length of Employment: _____ Schedule: _____

Marital Status: S, M, D, W Spouse: _____ Date of Birth: _____

Names of Children:
1. _____ Date of Birth: _____ School: _____
2. _____ Date of Birth: _____ School: _____
3. _____ Date of Birth: _____ School: _____

Name of Primary Care Physician: _____ Tel # _____
Do you want us to disclose any information to your PCP or other healthcare provider? _____Yes _____ No

Reasons for considering psychological services/stress management at this time:
_____
_____

Have you been referred to this practice? If yes, by whom? _____

Are you currently receiving healthcare (including counseling) at this time? If yes, with whom? _____

Have you ever been hospitalized? If yes, for what? _____
When? _____ Where? _____

Do you have current or past addictions to caffeine, nicotine, work, alcohol and/or other substances? If so, please circle and comment: _____
Please list current medications: _____

Insurance Information

Insurance Co. Name: _____ ID # _____
Group #: _____
Signed: _____ Dated: _____