Confidential Client Information

My Sincere Welcome to you. I look forward to helping you. Please fill in all areas as completely as possible.
All information you provide here is private, protected and confidential as described on other Intake Forms.

We request copy of insurance card and driver license. (Generally intended to keep people from using other's benefits.)

Client Last Name: First: Mid.

Client Age: Birth Date: / / Place of birth: Client SS# - -

Client Member ID# Employer and Occupation:

Primary Insurance (Health Plan) Name: (Best to copy **Both Sides** of Card)

Primary Ins. Co. Group/Policy/Account # **Primary** Ins. Co. Payer ID#

Subscriber Name: (If not Client) Sub. SS# - -

Subscriber Address: (or Same) Sub. Relation to Client:

City: State: Zip: Sub. Birth Date: / /

Address for **Billing** Correspondence: (Same as Above?)

City: State: Zip:

Subscriber Preferred Phone: Subscriber Employer/Occupation:

Parent or Guardian Name: (if Minor Client)

Client Preferred Phone: home cell work # OK to Leave Messages? Yes No

Add Phone: home cell work # OK to Leave Messages? Yes No

Add Phone: home cell work # OK to Leave Messages? Yes No

(Do remember, e-mail is Not considered 'Secure' unless specifically encrypted)

Client Preferred E-mail: OK to Leave Messages? Yes No

Add E-mail: OK to Leave Messages? Yes No

Name of **Secondary** Health Plan (if any) Client **2nd Plan** ID#

Secondary Ins. Co. Group/Policy/Account # **Secondary** Ins. Co. Payer ID#

2nd Subscriber Name: (or Same) 2nd Subscriber Birth Date: / /

2nd Subscriber Address: (or Same) 2nd Subscriber Relationship to Client:

City: State: Zip Code:

2nd Sub. Preferred Phone: 2nd Sub. Emp./Occup:

Please feel free to use back side if more space is needed.

Name of Person to contact in case of emergency:

Their Relationship to you: Their Phone:

Your Primary Clinic / Doctor: Their Phone:

Would you like to have me share information with your Primary Clinic / Doctor? Yes or No
If Yes, we are required to complete a proper Release of Information Form.

Are there any significant current or past medical problems: Yes or No

If Yes, this is something we should discuss in our first session.

Are you presently prescribed any medications? Yes or No

If **Yes**, please list them, the dosage and approximately how long for each. If **No**, have you considered a referral for medication?

Have you had mental health, alcohol/chemical assessments or counseling before? Yes or No

If yes, please write clinician name, the approximate dates you started and stopped; and, approximate number of sessions.

Would you like to have me share information with any or all of the previous professionals? Yes or No
If Yes, we are required to complete a proper Release of Information Form.

Have you ever gone to the ER or been hospitalized for a psychological difficulty? Yes or No
If Yes, this is something we should discuss in our first session.

Current relationship status: Single Married Partnered Separated Divorced Widowed

Partner's first name: Age: Years Together:

If you have children, please list their names and ages. It is likely we will talk more about them in session.

If your pets are an important part of your life, please write something about them too.

Please feel free to use back side if more space is needed.

Thank You for completing this paperwork. It will help us on to a good start and a better use of our time together.