THE CENTER FOR COUNSELING ARTS
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THECENTERFORCOUNSELINGARTS.COM
WHERE THE QUALITY OF CARE MATTERS & COUNSELING IS AN ART

For Staff Only:

Procedure Code: _____

DS: _____

Therapist: _____

OUR INTAKE FORM

Welcome to the Center for Counseling Arts, where we are committed to helping you explore solutions and promise the highest quality of care.

This packet contains four sections, and requires approximately five minutes to complete. You may also complete and submit our intake online on our website (*https://thecenterforcounselingarts.com/onlineintake*).

Please complete all fields, and checkmark and circle the options that are best.

Your Full Name: _____

Preferred Pronouns: **he/him/his/** **she/her/hers** **them/their/theirs**

Parent or Guardian: _____
(if minor)

Today's Date: ____/____/_____

Selected Therapist: _____

Date of Birth: ____/____/_____

Street Address:

_____

_____

City: _____ State: _____

Zip:_____

Email: _____

What phone number would you prefer we call for necessary communications and in the event of scheduling questions?

Preferred Phone: _____

☐ **My preferred phone is my cell / mobile**

☐ **My preferred phone is my home**

☐ **My preferred phone is my work**

May we leave you voice mail at this number?

YES **NO**

Would you like us to know a secondary number to call for necessary communications and in the event of scheduling questions?

Secondary Phone: _____

☐ **My secondary phone is my cell / mobile**

☐ **My secondary phone is my home**

☐ **My secondary phone is my work**

May we leave you voice mail at this number?

YES **NO**

Emergency Contact Person: _____

Relationship to ECP: _____
(my ECP is my spouse, friend, parent, etc.)

ECP Phone: _____

Employment & Insurance:

Employer: _____

Occupation: _____

Level of education completed: _____

Health Insurance Provider: _____

Health Insurance Provider Mailing Address:
(often on the back of your Health Insurance ID Card)

_____

_____

City: _____ State: _____

Zip:_____

Provider Phone:_____

Insurance Subscriber Name *(if other than you)*:

_____

Date of Birth *(if other than you)*: ____/____/_____

Your Insurance ID#: _____

Group Number: _____

Employer ID#: _____
(if listed on insurance card)

Personal & Medical:

Relationship Status:

Married Partnered Single Separated Divorced Widowed

If applicable, number of children: _____

Ages: _____

Has a medical doctor treated you in the last 6 months?

YES NO

If so, for what medical condition?

_____

Are you still being treated? YES NO

Current medical conditions or concerns:

_____

_____

Chronic conditions:

_____

_____

Has your physician referred you? YES NO

Current prescribed medications:

_____

Allergies:_____

Primary Care Physician: _____

Phone:_____

Psychiatrist (if applicable): _____

Mental Health History:

Have you ever been in therapy? YES NO

If so, for how long? _____

Which year or years? _____

Name(s) of former therapist(s):

_____

Have you been hospitalized for a mental health condition?

YES NO

Where? _____

When? _____

Do you use alcohol? YES NO

Amount: _____ Frequency: _____

Do you use tobacco products? YES NO

Type: _____ Frequency: _____

Do you use other drugs? YES NO

What type? _____

Amount: _____ Frequency: _____

What current stresses influence your mental health? Do you have any related concerns?

_____

_____

_____

_____

_____

_____

Is there a history of depression, anxiety or mental health concerns in your family?

YES NO

Family Member: _____

Condition: _____

Did they or are they receiving treatment? YES NO

How were you referred to the Center?

_____

May we email you regarding future events or workshops at the Center? YES NO