THE CENTER FOR COUNSELING ARTS

where the quality of care matters & counseling is an art

INTAKE INFORMATION

For Staff Only:

Procedure Code: ____________

D_S: ________________________

Therapist: ___________________

Name: ____

Parent or Guardian (if minor):

____

Today's Date: ____/____/________

Selected Therapist: ____

Date of Birth: ____/____/_________

Street Address: ____

City: _________________________ State: ________________ Zip:_____________

Email: ____

Telephone Numbers: (Home) ___________________ (W) ______________________

(Cell) ____________________ (Pager) ___________________

May we call you at home? YES / NO May we call you at work? YES / NO

May we leave voice mail at home? YES / NO At work? YES / NO

Emergency contact person: __________________________ Phone: ____________________

Employment & Insurance Information

Employer: ____ Occupation: _______________

Level of education completed: _______________________

Name and mailing address of insurance company: _______________________________

____
(See back of insurance card)

Insurance company phone number: ___________________________

Insurance Subscriber Name & D.O.B. (if other than you): __________________________

____

Your Insurance ID#: ____

Group Number: ______________________________ Employer ID#: ________________
(if listed on insurance card)

____

Circle Status: (If applicable)

Married Partnered Single Separated Divorced Widowed

Number of children: _____________ Ages: _____________________________

Medical Information

Has a medical doctor treated you in the last 6 months? YES / NO

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

For how long? _______________ Which year or years? _______________

Name(s) of former therapist(s): ____

Have you ever 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 types of drugs? ______________________

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 currently 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 /

I'll tell you later