

PHONE INTAKE

Caller's Name: _____ Referred By: _____

CLIENT INFORMATION

Client's Name: _____ **Relationship to Caller:** _____

Address: _____ **Best Number to reach you?** _____

Times of availability for counseling appointments: _____

Date of Birth: _____ **Sex:** M/F

Nature of Problem: _____

Duration of Problem: _____ **Abusive:** Yes/No **Alcohol/Drugs:** Yes/No **Suicidal:** Yes/No

If yes explain: _____

Previous Counseling: Yes/No **Yes with:** _____ **when:** _____

Diagnosis: _____ **pre-termina:** _____

Marital Status: S D W Sep. _____ **How Long:** _____ **Married:** _____ **Divorced/Widowed/Separated:** _____

Spouse's Name: _____ **Date of Birth:** _____

Children's Names and Ages: _____

IF CLIENT IS A MINOR

Name of Primary Caregiver(s): _____ **Relationship to Client:** _____

Place of Education: _____ **How Long?** _____ **Grade:** _____ **Period:** _____

Siblings' Names and Ages: _____

ADMINISTRATIVE

How were you planning on paying for the counseling: Out of pocket? _____ Insurance? _____

Fees Quoted: Intake _____ OV _____ **Sliding Scale:** Y/N **Estimated Annual Income:** _____

Mental Health Insurance Provider: _____ **Phone Number:** _____

Insured's Name: _____ **Insured's Policy Number:** _____

Insured's Employer: _____

Client Relationship to Insured: _____ **Effective Date:** _____

Do you want to be added to the mailing list? _____ Yes _____ No **Email Address:** _____