Intake Information Date____________

____
Name of Client date of birth

____
address

____
city State zip

____
Daytime phone Cell Evening phone
(please note if OK to call or leave a message)

____
Email address Social Security number

____
Name of Partner/Spouse date of birth

____
partner/spouse phone number

Emergency Contact if other____

____
Place of Employment

____
How long at this job? Level of stress ?

Do you have a medical condition? (please list length and severity)

____

____

____
Name of physician (PCP)

____
PCP address phone
Fax_____________

Current medications you are taking: dose/ reasons for/ how long taking?

____

____

____

____

____
Level of pain? average 1- 10 (10 being most severe)

History of Substance Abuse:

Have you ever had treatment for drug or alcohol abuse?
When? Where?
____

____

____

Have friends/family/coworkers expressed concern about the drugs or alcohol you consume?_____________yes/no
Do you have concern about the drugs or alcohol you consume? _________yes/no____

Insurance Information

Name of Insurance ID number

____

Group Number____

Insurance Address

____

____

Insurance phone number ____

____

Name of Primary insured date of birth of Primary

____

Relationship to client

General reasons for seeking counseling at this time?

____

____

____