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LCS 28329

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ADULT INTAKE INFORMATION

Client's Name_____ Today's Date:_____
Last First MI

Address:_____
Street or PO Box City State Zip

Mailing Address(if different)_____
Street or PO Box City State Zip

Email Address:_____

Your Age:_____ Date of Birth:_____

Married_____ Separated_____ Divorced_____ Widowed_____

Committed Relationship_____ Never Married_____

Referred by?_____

Contact Information:

Home Phone#:_____ Cell Phone#:_____

Employer:_____ Work #:_____

Job Title:_____

Are there any restrictions on calling or leaving a message? Yes_____ No_____

What restrictions?_____

Best phone number to leave message concerning your appointments:_____

Spouse/Partner's Name:_____DOB:_____ Age:_____

Spouses/Partner's Home Phone (if different)#:_____ Work Phone#:_____

Spouses/Partner's Employment:_____

PRESENTING PROBLEM(S)

Briefly describe why you are here:_____

_____

_____

_____

What would you like to accomplish as a result of your therapy here?_____

_____

_____

_____

Other's in Household:

Name	Age	Relationship to you

Whom may we contact in case of an emergency?: Name:_____

Phone #:_____ Relationship:_____

Physician's Name:_____ Phone #:_____

EDUCATIONAL HISTORY

Presently enrolled in school? **YES** _____ **NO** _____ Highest grade completed?_____

MILITARY HISTORY

Have you served in the armed forces? **YES**_____ **NO**_____ Branch:_____

When:_____

INSURANCE INFORMATION

Name of Insurance Carrier:_____

Responsible Party: _____Relationship to Responsible Party:_____

Do you have mental/behavioral health coverage? **YES**_____ **NO**_____ What is copay per visit? _____

Contact Information for Insurance Co._____

ADDITIONAL NOTES/INFORMATION THAT MAY BE IMPORTANT

_____

_____

_____

_____