

Confidential Intake Form

Date: _____ **Patient** SSN: _____ - _____ - _____

Patient Name: _____
Last First M.I.

Address: _____

City: _____ State: _____ Zip: _____

Email _____ @ _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ Ext: _____

Pager?: (____) _____ - _____ Cell?: (____) _____ - _____

Gender: Female Male Date of Birth: _____ - _____ - _____ Age: _____

Marital Status: Married Single Divorced Separated Widowed NA

Employment Status: employed student employed/student unemployed

Employer: _____ Type of Work _____

Insured Name: : _____
Last First M.I.

Insured Date of Birth: _____ - _____ - _____ **Insured** SSN _____ - _____ - _____

Insurance Company: _____

Managed Care Company: _____

Referral Source: _____

Primary Care Physician: _____ Phone: _____

Outpatient Therapist: _____ Phone: _____

Residence Situation: Private Household Group Home Nursing Home Other Residential Facility
 Homeless Shelter Jail or Correctional Setting

Educational Level (Highest Grade Completed): _____

less than high school some college some high school college graduate
 high school graduate post-graduate work graduate degree

Military Service: Yes No

If Yes, Status: Active Honorable Discharge Medical Discharge Dishonorable Discharge

In Case of Emergency, Contact:

Name: _____ Relationship: _____

Phone: _____

If patient is minor fill out the information below for at least one:

Mother (or Guardian)

Father (or Guardian)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email _____@_____

Home Phone:(____)____-____ Work Phone:(____)____-____ Ext:_____

Pager? :(____)____-____ Cell? : (____)____-____

Additional Contact Information: