Jim Cosenza, LCSW, CADC

4753 N. Broadway, Suite 608, Chicago, IL 60640
Voice: 773-633-6643 • Fax: 773-275-3880
jim@jimcosenza.com • jimcosenza.com

Intake Information

Date: _____

Name (Preferred): _____
First Name Middle Initial Last Name

Name (Legal): _____
(May leave blank if same) First Name Middle Initial Last Name

Address: _____
Street Apt. Number City State Zip

Date of Birth: _____ SSN: _____

Email Address: _____
Can leave confidential message? **YES NO**

Home Telephone: _____
Can leave confidential message? **YES NO**

Work Telephone: _____
Can leave confidential message? **YES NO**

Mobile Telephone: _____
Can leave confidential message? **YES NO**

Gender (Preferred): _____ Gender (Legal): _____

Orientation: _____ Partner Status: _____

Occupation: _____ Length with Current Employer: _____

Employer or Institution Name: _____

Emergency Contact Name: _____

Relationship to you: _____ Telephone Number: _____

Payment for Services (please circle) Self-Pay Insurance EAP

If Using Insurance or EAP:

Insurance Company or EAP Plan Name: _____

Insured's ID Number: _____

Insured's Group Number: _____

Phone Number for Insurance Benefits or EAP: _____

Insured's Name: _____ Insured's SSN: _____
If different from the name above If different from the number above

Insured's Date of Birth: _____ Insured's Gender: _____
If different from the date above If different from the gender above

Insured's Employer's Name: _____
If different from the name above

Insured's Address: _____
If different from the address above: Street Unit City State Zip

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Referral Source: _____