

INTAKE INFORMATION FORM

Date: _____

Name: _____
Last Name First Name Middle Initial

Address: _____
Street City State Zip

Date of Birth: _____ SSN: _____

Email Address: _____
Can leave confidential message? YES NO

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

Mobile Telephone: _____
Can leave confidential message? YES NO

Orientation: _____ Gender: _____

Partner Status: _____

Emergency Contact: _____

Relationship to you: _____ Telephone Number: _____

Occupation: _____ Length with Current Employer: _____

Employer or Institution Name: _____

Paying 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 City State Zip

Referred By: _____