Client Intake Information

Office Use Only

Therapist _____ Start Date _____

Ins Dx Fee _____

Ref:

Today's Date _____

The information requested in this form will be kept CONFIDENTIAL *and will help your therapist assist you.*

GENERAL INFORMATION - Please Print

Name: Last_____ First _____ MI ____

Mailing address_____ City_____ State_____ Zip_____

PHONE (circle preferred number)	Leave message?
Home _____	Y N
Work _____	Y N
Cell	Y N

Email Address _____

Since email is not secure, we would use it for communication about appointments only. Your permission to do so is denoted by your initials here _____

Birth date ___/___/___ Birth Place _____ Age_____ Gender_____

Employer _____

Your racial/ethnic identity: ☐ African-American ☐ Black ☐ Native-American ☐ Asian-American ☐ Multi-racial ☐ White/Caucasian ☐ Hispanic ☐ Other _____

Marital Status: ☐ Single ☐ Dating ☐ Married/Partnered (# years_____) ☐ Separated ☐ Divorced ☐ Widowed

Spouse/Partner's Name _____

How did you hear about us? ☐ Internet ☐ Family/Friend ☐ Clergy ☐ MD ☐ Brochure ☐ Yellow Pages ☐ Therapist

Your religious preference: ☐ Agnostic ☐ Atheist ☐ Buddhist ☐ Christian ☐ Hindu ☐ Jewish ☐ Muslim ☐ No Preference ☐ Other _____

Does your religious or spiritual preference play an important role in your life? ☐ Very important ☐ Important ☐ Neutral ☐ Unimportant ☐ Very Unimportant

Type of counseling you are seeking: ☐ Individual ☐ Couples ☐ Family

EMERGENCY CONTACT - Name _____ Relationship _____ Phone _____

Client's Authorization for Treatment and Payment:

"I realize I am obligated to pay for any appointments I did not cancel at least 24 hours in advance."

↓ Please turn over for side two ↓

Client's Signature *Date*

CONFIDENTIAL *Client's Name (Printed)*

MEDICAL & PSYCHOLOGICAL HISTORY

Physician's Name _____ Physician's Phone # _____

Date of last physical _____

List any current physical illnesses or symptoms _____

_____

List current medications _____

Have you ever been given a mental health diagnosis by a mental health therapist? ☐ Yes ☐ No When? _____

Therapist's Name _____ Therapist's Phone #_____

Have you or any other family member received help for drug or alcohol dependency? ☐ Yes ☐ No

When? _____ Where?_____

Do you want to use insurance benefits? ☐Yes ☐No Are you: ☐ Primary Policyholder or ☐ Dependent

Insurance Company Name: _____ Insurance Company Phone #:_____

Insurance ID #_____ Group #_____ Policyholder's Name:_____

Policyholder's Birthday:_____ Relationship to Policyholder:_____ Policyholder's Employer:

_____

Client's Authorization for Insurance Use:

I authorize the release of health care information necessary to process any claims generated in my behalf by Discovering Your Truth LLC/ValerieMondesirLMFT.

I hereby authorize payment directly to Discovering Your Truth LLC/ValerieMondesirLMFT of any benefits due me for counseling / psychotherapy. I understand that I am responsible for any amount not covered by insurance.

Client's Signature Date Client's Signature Date