Client Demographics & Intake Information
(ONLY applicable to those using insurance)

Client's Name: _____ Client Social Sec # :_____

DOB: _____ Age:_____ Sex: _____ Marital Status: _____

Client Status: _____ Employed _____F/T Student _____P/T Student _____ Work at Home

Client Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Other Phone: _____

Is it okay to leave messages? _____

Immediate Family System (Children / Siblings / Parent / Spouse / Significant Other) and ages: _____

_____

In Case of Emergency Notify: _____

Phone: _____ Relationship:_____

How were you referred: _____

** If you would like me to file with your insurance, **You Must complete the following, or you will be responsible for your visits**. Be sure that a copy of your current insurance card has been attached to your file.

Have you called your insurance company to verify benefits and request authorization? _____

Authorization Number: _____ **# Sessions:** _____

Insurance Company or EAP Name: _____

Insurance Phone # & Billing Address: _____

ID # if different from social: _____ Group Number if any:_____

Primary Insured Name _____ Relation to client: _____

Primary Soc. Sec:_____ Primary Insured DOB: _____

Primary Insured's Employer: _____

Primary Insurance Holder if different from client:

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Other Phone: _____

Is the client covered by a secondary health insurance policy? Y / N

If Yes, please request an additional form and fill out the same information for the secondary company.

Signature: _____ Date: _____