THE COUNSELING COLLABORATIVE

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Intake Information

Client Name:_________________________________ **Date:** ____________
First/Last/Middle Initial

Preferred Pronoun: _______________(he/she/them, etc)

Date of Birth: _______________ **Current Age:** ____ **Marital/Relationship Status:** _________
mm/dd/yyyy

If under 18, Parent/Guardian Name: ____

Mailing Address:____
____

Physical Address (if different from above): ____
____

Home Phone: _________________ **Cell Phone (client):** ___________________________________

Work Number: ________________ **Cell Phone Parent/Guardian (if applicable):** _______________

Email: ________________________________

Permission to text and email client ___ **Yes** ___**No Signature:** ___________________ **Date:** ______

Emergency Contact: _____________________________________ **Relationship:** _____________

Emergency Contact Phone Number: ____

Current Family Members (names, relations & ages):
____
____

Major Medical Conditions/Allergies:
____
____

Current Medications ____
____

Medications Prescribed by: ____

Primary Care Physician: _______________________________________ **Phone #:** _____________

Referred By (including self): ____

Briefly, what do you hope to gain from counseling?
____
____

Prior mental health treatment & mental health hospitalizations (providers & dates):
____

Prior Diagnosis if known: ____

Employment Status: ☐ **Full Time** ☐ **Part Time** ☐ **Not Employed** ☐ **Seasonal** ☐**Student**

PLAN FOR PAYMENT:

☐ Self-Pay ☐ Please bill my insurance (Insurance companies will be billed directly. It is the client's responsibility to check with all other insurance providers about out of network coverage. Co-pays and out of pocket payments are required at the time of service. Clients are responsible for payment if their insurance company does not pay.)

INSURANCE INFORMATION:

Relationship to insured (policy holder) : ☐ Self ☐ Spouse ☐ Child ☐ Other: _____________

Co-Pay Amount: $______________

COMPLETE IF RELATIONSHIP TO INSURED IS OTHER THAN "SELF":

Name of Insured (policy holder): ____
First/Last/Middle Initial

Address of Insured: ____
Street/PO Box Town, State, Zip

Phone # of Insured: ______________________________ DOB of Insured: ________________

Social Security # of Insured: ________________________________

Employer of Insured: ____

Insurance Company: ____

Insurance Company Phone #: _____________________________________

Insured's ID#: _____________________________________ Group #: ____________________

Plan: ____

RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS:

I authorize the release of only necessary medical or other information required to process insurance claims. I also authorize payment of medical benefits to provider for services performed:

Client Signature: ___________________________________ Date: ________________
Parent/Guardian Signature: ___________________________________ Date: ________