CHERYL LAFLAME, PSY.D.

Initial Intake Form

Date: _______________

Client Name: ____
(Please print) First Last

Address:____

City:_______________________________ State:_______

Zip Code: ___________

Sex: _____ Age: _____ SS#_____/_____/_____

Birth date: _____/_____/_____

Phone: Home________________ Work: _____________________

Cell: _____________ E-mail address: _______________________

Name of Legal Guardian (if applicable): _____________________________________

Marital Status (Please circle): Married Divorced Separated Widowed Single

Education (Please Circle): Elementary School Some High School High School/GED
Some College College Graduate Master's Degree Doctorate

Referred by: _______________________________
Previous Counseling? Y N

If yes, When? _______________ Where? __________________

Duration?_______________

Why? ____

Current Reason for seeking psychological services:
____

____

Primary Care Physician (PCP): _____________________

Phone No. ________________________

PCP Address: ____

Current Medications: ____

Insurance Company: _____________________

Insured's Name: ______________________

Insured's DOB_________________

Insured's Policy Group: _________________________

Secondary Insurance (if applicable): ____

I hereby authorize by my signature that:

1. _____ (Y/N) Cheryl LaFlame, Psy.D. may contact and coordinate my treatment with my Primary Care Physician.
2. _____ (Y/N) As insured or authorized person, I hereby assign any insurance benefits to Cheryl LaFlame, Psy.D. and authorize her to furnish information necessary to process claims.
3. _____ (Y/N) Cheryl LaFlame, Psy.D. has my permission to call/email me for follow up contact after my last appointment.

Client/guardian signature: ____

Best way to contact for follow-up:
____

(Y/N) A message may be left.
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