

# NEW CLIENT PHONE INTAKE FORM

Date:		Notes:
Appt Scheduled		
Entered in Psyquel		

Day of Appointment:
Time of Appointment:
Counselor:

## PERSONAL INFORMATION

Client's Full Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

If Child, List Parent/Guardian Name(s) \_\_\_\_\_

Home Address: \_\_\_\_\_ Phone (Home) \_\_\_\_\_

\_\_\_\_\_ Phone (Work) \_\_\_\_\_

\_\_\_\_\_ Phone (Cell) \_\_\_\_\_

Email \_\_\_\_\_

Have you been to this Counseling Center? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, when \_\_\_\_\_

Are you a MEMBER of First Baptist of Orlando? \_\_\_\_\_ Yes \_\_\_\_\_ No

Referred by: \_\_\_\_\_

## PRIMARY INSURANCE

Insured's Name \_\_\_\_\_

Employer \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_

Insurance Company \_\_\_\_\_ Ins Co. Phone Number \_\_\_\_\_

Insured's ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

## SECONDARY INSURANCE

Insured's Name \_\_\_\_\_

Employer: \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_

Insurance Company \_\_\_\_\_ Ins Co. Phone Number \_\_\_\_\_

Insured's ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

## EAP INFORMATION

Employer \_\_\_\_\_ EAP Company \_\_\_\_\_

Authorization # \_\_\_\_\_ Number of Sessions Approved \_\_\_\_\_

Presenting Problems \_\_\_\_\_