Micah Counseling Services

Counseling – Coaching – Consulting

Client Intake Form

Date: ____________________

Basic Information – Please Print

Name: Last _________________________________ First: ____________________________________ MI: _________

Mailing Address: ____ City: _______________________ State: _____ Zip: ________

Responsible Party (if different than above)

Name: Last _________________________________ First: _____________________________________ MI: _________

Mailing Address: ____ City: ________________________ State: _____ Zip: ________

Home Phone: _______________________________________ Leave Message? ___ Yes ___ No
Work Phone: ______________________________________ Leave Message? ___ Yes ___ No
Cell Phone: ______________________________________ Leave Message? ___ Yes ___ No
Email Address: ______________________________________

DOB: _____ / ______ / ______ Age: _______ ___ Male ___ Female ___ Other SSN: ______ - ______ - ______

Emergency Contact: __________________________________ Telephone: _____________________________
Relationship to You: __________________________________

Marital Status: ___ Single ___ Married/Partnered ___ Separated ___ Divorced ___ Widowed

Spouse/Partner's Name: ____ Number of years together: ________

Religious/Spiritual Preference: ____
Referred by: ____ May we thank the person? ___ Yes ___ No

Insurance Information (Aetna Only)

Policyholder's Name: ____ Policyholder's Employer: ________________________

Street Address: _______________________________________ City: __________________________ State: ______ Zip: ________

Policyholder's SSN _____ - _____ - _____ Policyholder's DOB: ____ / ____ / ____ Relationship to Client: _____________

Primary Insurance Carrier: ______________________________ Street Address: _____________________________________

City: ________________________ State: _____ Zip: ________ Policy#: ____________________ Group#: __________________

Preauthorization Required? ___ Yes ___ No Phone: ________________________________

Would you like to join our email list for upcoming workshops or groups? ___ Yes ___ No

Counseling / Coaching Concerns

Briefly describe why you are seeking counseling currently?

____

____

____

What would you like to see happen because of counseling / coaching?

____

____

How would you rate your family relationships? Poor Distance Close

Medical and Psychological History

Physician's Name: ______________________ Physician's Phone: ______________________
Date of last physical: ______________________
List physical illnesses or symptoms: ___ Check if none

____
____

Current Medication Dosage Frequency Prescribing MD
____
____

Psychiatrist's Name: ______________________ Psychiatrist's Phone: ______________________

Have you been in counseling before? Yes ___ No ___ If yes, when? ____________ With whom? ____________

If applicable, what was your experience in counseling?
____
____

How many days per week do you exercise? 1-2 3-4 5 or more

How would you rate your diet? Poor Balanced

Please check the following you use as well as note the amount and frequency:

___ Caffeine: ______________________ ___ Tobacco: ______________________
___ Alcohol: ______________________ ___ Marijuana: ______________________
___ Cocaine, Crack: ______________________ ___ Other: ______________________

Have you ever had a DUI? ___ Yes ___ No If yes, how many? ________ When? ______________________

(The Information in this form will be kept strictly confidential)