New Patient Preliminary Client Intake Form

DATE:

Name ____
(Last) (First) (Middle Initial)

Name of parent/guardian if under 18 ______________________________
(Last) (First) (Middle Initial)

Birth Date: ___/___/___ **Age** **Birth Gender** **Male**
Assigned Gender **Female**

Marital Status: **Married** **Never Married** **Domestic Partner**
Separated **Divorced** **Widowed**

Address : ____
(number and street name)

____
(city/state/zip code)

Cell Phone: ( )
May we leave a message?
Yes **No**

Home Phone ( )
May we leave a message?
Yes **No**

Email Address: ______________________ **May we email you?** **Yes** **No**

Referred by (if any): ______________________________________

Reason for Referral: ______________________________________

Previous Therapist/Practioner: ______________________________

List current prescribed medications you are taking: ______________

____

Insurance Information:______________________________________
(Name of Provider)

______________________ (Group Number)

______________________ (Member ID/Number)

Email Completed Form to info@adkinsfamilycounseling.com