Derfus Counseling Services

INTAKE FORM

Name: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Okay to leave messages? Voice: Y N Text: Y N

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Status: Single ____ Cohabitating ____ Married ____ Separated ____ Divorced ____ Widowed ____

Occupation: _____ Employer: _____

How would you rate your physical health? _____

Are you taking medications? _____ If so, please list

_____

_____

Name of your primary physician: _____

Address of your primary physician: _____

Name of your psychiatrist if applicable: _____

Address of your psychiatrist if applicable: _____

Have you ever seen a counselor or been hospitalized for mental health / emotional reasons? _____
If so, who / what hospital:

Name: _____

Address: _____

Complete if applicable:

Spouse's name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Who referred you? _____

Reason for seeking counseling:

_____

_____

_____

_____

Insurance Company: _____

Subscriber # _____ Group # _____

Subscriber name: _____ _____

Subscriber Street Address: _____

City: _____ State: _____ Zip Code: _____

Subscriber employer: _____

Subscriber Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

I authorize Derfus Counseling Services to directly bill my insurance company for services. I authorize payment of medical benefits to be paid directly to Derfus Counseling Services.

Signature Date