



# 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: \_\_\_\_/\_\_\_\_/\_\_\_\_ Email Address: \_\_\_\_\_

Status: Single \_\_\_\_ Cohabiting \_\_\_\_ 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: \_\_\_\_\_

Initials: \_\_\_\_\_

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: \_\_\_\_/\_\_\_\_/\_\_\_\_

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