

INTAKE FORM

Referral Date: _____ **Start Date:** _____ **Close Date:** _____

Client Name: _____ **Gender:** M _____ F _____

Street Address: _____ **Date of Birth:** _____

City: _____ **SSN:** _____

Phone Numbers: _____ (Home) _____ (Work)

Guardians: _____ **Race:** _____

County Social Services? _____ (Name) _____ (Number)

Diagnosis? _____ (Name) _____ (DSM Code)

Current Clinical Concerns

Household Members

Insurance Information

Insurance Name _____ Policy # _____
Address _____ Group # _____

Phone# _____

Bill to: Client _____ Insurance _____ County _____ Other _____