

Integrated Counseling Center LLC

Intake Sheet

Appointment Date: _____

Time: _____

With: _____

Demographic Information

Date: _____ Time: _____ Referred By: _____

Caller _____ Relationship to Patient: _____

Parent/Guardian _____ Patient Name: _____

Gender: _____ Marital Status: _____ DOB: _____

Address: _____ City, State, Zip: _____

Telephone: _____ Other Number: _____

Employer/School: _____ Attending Yes ___ No: ___

Insurance Information

Card holder's employer: _____

Primary insurance company: _____

Primary insured SS#: _____ ID#: _____ Group# _____

Telephone number: _____ Prior Authorization Number _____

Secondary insurance company: _____

Employer of card holder of secondary insurance: _____

Service Request Information

Problem: _____

Prior mental health or substance abuse services?: Y ___ N ___ Where: _____

Pregnant Y ___ N ___

Current thoughts of suicide/homicide: Y ___ N ___ Plan: Y ___ N ___ Means: Y ___ N ___

Medications: _____

Health concerns: _____

Special needs: _____