Intake Form

PLEASE PRINT CLEARLY Today's Date ________________________

PERSONAL INFORMATION

PATIENT (S) ____

Date of Birth _______________________ Gender ___________

Address ____

____

City, State ______________________________Zip ___________

Home Phone ____

Work Phone ____

Cell Phone ____

RESPONSIBLE PARTY ____________________________________

Responsible Party's SSN ____________________________________

Address (if different) ______________________________________

____

City, State ___________________________________ Zip ________

Home Phone (if different) ___________________________________

Work Phone (if different) ___________________________________

Cell Phone (if different) ___________________________________

Please indicate with an * which phone numbers we may NOT leave a message.

Patients' relationship to Responsible Party (check one): Self_______ Spouse_______ Child_______ Other _______

Relative or friend in case of emergency ____

Name Phone # Relationship

Source of referral __________________________________ Reason for referral ____

How did you hear about Chesie Roberts or CLR Counseling Group?

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FINANCIAL

CLR Counseling Group, LLC will be happy to submit the claim for counseling services on your behalf. However, if for any reason your insurance denies the claim or your co-pay differs from the amount you paid you will be responsible for payment of services.

_______________________________________ ___________________________________ ____________________________

Signature of Responsible Party Printed Name Date

If you do not give 24-hour notice of cancellation prior to the scheduled appointment or no call no show you will be charged a cancellation fee of 50.00. You are required to provide a credit card number on file in the event that you break this cancellation policy.

___________________________________ _____________ ________ _________________________________

Credit card number Expiration date CVV code Name of card holder

FAMILY INFORMATION

NAME	M/F	AGE	DATE OF BIRTH	RELATIONSHIP TO PATIENT &/or MARITAL STATUS	EDUCATION	OCCUPATION
Patient (s)						
1.						
2.						
Parent (s)						
1.						
2.						
Children/Step Children/Siblings						
1.						
2.						
3.						
4.						
5.						
6.						
Others Living in Household						
1.						
2.						
3.						
4.						
5.						
6.						

MEDICAL INFORMATION

1. Patient Name ____

Have you ever been treated for emotional difficulties before (When and Where?) ____

____

Physician: Name/Practice _____________________________ Address________________________ Phone _______________________

Date of last physical exam _____________________________ Height ________________________ Weight _______________________

How is your general health now? ________________________ Medications? ____

Are you presently being treated by a physician for any physical condition? _____________________________________

Have you had any serious illness? (List) ____

Have you ever had any surgery? (List) ____

2. Patient Name ____

Have you ever been treated for emotional difficulties before (When and Where?) ____

____

Physician: Name/Practice _____________________________ Address________________________ Phone _______________________

Date of last physical exam _____________________________ Height ________________________ Weight _______________________

How is your general health now? ________________________ Medications? ____

Are you presently being treated by a physician for any physical condition? _____________________________________

Have you had any serious illness? (List) ____

Have you ever had any surgery? (List) ____

***If more than two patients, please indicate above medical information on separate sheet for other patients.**

PLEASE MARK ALL THAT APPLY: (If more than one patient, please separately initial)

___Anger	___Grief	___Paranoia
___Anxiety	___Guilt	___Physical Aggression
___Behavior Problems	___Hallucinations	___School/Work Problems
___Changes in Appetite/Eating Habits	___Hopelessness	___Self Abusive Behavior
___Criminal Activity	___Hyperactivity	___Sleep Disturbance
___Decreased Energy	___Impulsiveness	___Somatic Complaints
___Delusions	___Interpersonal Conflicts	___Suicidal Thoughts/Attempt
___Depressed Mood	___Irritability	___Weight Gain
___Disruption of Thought Process/Content	___Manic	___Weight Loss
___Emotional/Physical/Sexual Trauma	___Mood Swings	___Worthlessness
___Excessive Crying	___Oppositional	___Other (Specify)
___Family Conflicts	___Panic Attacks	

ow could your life be better?

o you have goals for therapy? If so explain?

there anything that you feel is important for me to know prior to our session?