PRIVATE CLIENT INTAKE

Identifying Information

Name: _____Date: _____

Address: _____ City: _____State: _____

Zip: _____Telephone: (Cell)_____

Can we send you text reminders of upcoming appointments? Yes _____ No _____

Age: _____ Date of Birth:_____Birth City, State: _____

Sex: Male /Female Email: _____

Marital Status: Married_____Single_____Divorced_____Widowed_____Separated_____

Employer:_____WorkPhone:_____

Address:_____City:_____State: _____

Zip: _____

Insurance Information

Self Pay: Yes_____ No_____

Primary Insurance
Insurance Name:_____
ID/Policy Number:_____
Group Number:_____
Co-Payment:_____
Policy Holder's Name (if other than you)_____
Policy Holder's DOB:_____

Secondary Insurance
Insurance Name:_____
ID/Policy Number:_____
Group Number:_____
Co-Payment:_____

2647 Narnia Way, #102
Land O' Lakes, FL 34638-7265
813-994-5595 Phone
813-994-5504 Fax
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Please list medications that you currently take: _____

_____

What issues/concerns would you like to address?_____

_____

How long has this been a concern?_____

Have there been any changes in your (please check any that apply):

Marriage Yes__No__ **Family** Yes__No__ **Family of Origin** (Extended Family)Yes__No__

Education Yes__No__ **Vocation** Yes__No__ **Daily Functioning** Yes__No__ **Legal Status** Yes__No__

Medical Condition Yes__No__ **Mood** Yes__No__ **Anxiety Level** Yes__No__

If you feel depressed, what are your symptoms?_____

_____

If you are anxious, what are your symptoms?_____

_____

<u>If your problem includes concerns over abuse of alcohol:</u>

Have you ever felt like you should cut down on your drinking?	Yes	No
Have people annoyed you by criticizing your drinking?	Yes	No
Have you ever felt bad or guilty about your drinking?	Yes	No
Have you ever had a drink first thing in the morning to steady your nerves?	Yes	No

How many times per month do you drink to intoxication?_____

Was anyone in your family an alcoholic?_____

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If your problem includes concerns over drug abuse:

What drugs other than alcohol have you used?_____

When did you last use these drugs? _____

When using how much do you spend on drugs in a week? _____

Has drinking or drug use ever caused you to miss or be late for work? _____

Has drinking or drug use ever affected your relationships or home life? _____

Has your physician ever told you to cut down or quit? _____

Is there history of drug addiction in your family? _____

Have you ever attended an AA/NA or other mutual support group? Yes__No__

Thank you for taking the time to fill out this form as it will help us help you.

Print Name:_____

Sign Name:_____

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