CLIENT INTAKE INFORMATION FORM

HIGH POINT FAMILY THERAPY SERVICES

Office Use Only

Client #_____ Ins Dx_____
Therapist _____ Ther#___Loc_____

Today's Date _____

The information requested in this form will be kept confidential and will help your counselor assist you.

GENERAL INFORMATION – *Please print*

Name: Last_____ First _____ MI ____

Mailing Address_____ City_____State___Zip_____

Phone (circle preferred number) Leave message? Email Address_____
Home_____ Y N Would you like to be on our email list for
Work _____ Y N upcoming workshops and groups? Y N
Cell _____ Y N

Birth date ___/___/___Age____ ☐ Male ☐ Female Social Security #_____-___-_____

Place of Employment_____

Your racial/ethnic identity: ☐ African-American ☐ Native American ☐ Asian-American
☐ White/Caucasian ☐ Hispanic ☐ Other

Marital Status: ☐ Single ☐ Married/Partnered (# years ___) ☐Separated ☐ Divorced ☐ Widowed

Spouse/Partner's Name _____

How did you hear about us? ☐ Clergy ☐ M.D. ☐ Brochure ☐ Family/Friend ☐ Internet ☐ Insurance
☐ Therapist ☐HPFTS Client Referred by: _____

Religious/denominational preference: _____

Type of counseling you are seeking: ☐ Individual ☐Couples ☐ Family ☐ Group

EMERGENCY CONTACT Name _____ Relationship _____ Phone_____

Are you using insurance benefits? ☐ Y ☐ N Insurance Company Name: _____

Are you: ☐ Primary Policyholder ☐ Dependent Insurance ID # _____Group #_____

Policyholder's Name:_____ Policyholder's Birthday: _____ Policyholder's SSN: _____

Relationship to Policyholder:_____ Policyholder's Employer:_____

Client's Authorizatio for Insurance Use

I authorize the release of health care information necessary to process any claims generated by High Point Family Therapy Services, PLLC.

_____
Signature Date

Client's Payment Agreement

I hereby authorize payment directly to High Point Family Therapy Services, PLLC of any Benefits due me for counseling / psychotherapy. I understand that I am responsible for any amount not covered by insurance.

_____
Signature Date

COUNSELING CONCERNS

Why are you seeking help now? _____

_____

_____

What would you like to see happen as a result of counseling or psychotherapy? _____

_____

_____

_____

MEDICAL & PSYCHOLOGICAL HISTORY

Physician's name & phone number _____ Date of last physical_____

List physical illnesses or symptoms _____

_____

List current medications _____

_____

Psychiatrist's name & phone number _____

Have you received psychotherapy or counseling in the past? ☐ Y ☐ N

When? _____ With whom? _____

Have you or any other family member received help for drug or alcohol dependency?
☐ Y ☐ N When? _____ Where? _____

TREATMENT PLAN
(To be completed in session with your therapist)

Type of counseling: ☐ Individual ☐ Couple ☐ Family ☐ Group

Frequency of therapy _____

Treatment Goals _____

_____

_____

_____

_____

Referrals (specify): _____

_____

Client's signature _____Date_____

Therapist's signature _____Date_____

Therapist's Credentials _____