Individual & Family Therapy

Holly R. Dunn MSW, LCSW
Holly Rothenbush LMFT, BCBA

INTAKE FORM

(Please fill out completely)

CLIENT INFORMATION

First Name:_____ Last Name:_____ Age:_____
Sex:_____

DOB:_____ SSN:_____
Email:_____

Address:_____ City:_____ State:____ Zip:_____

Telephone: Home:_____ Home Fax:_____
Cell/Mobile:_____

Office:_____ Office Fax:_____
Pager:_____

Employer:_____
Occupation:_____

Employment Status: Full-Time:____ Part-Time:____ Self-Employed:____ Disabled:____

Leave of Absence:____ Not Employed:____ Retired:____
Student:____

If client is a child

Father's Name:_____
Address:_____

Home:_____ Work:_____ Cell:_____
Employer:_____

Mother's Name:_____
Address:_____

Home:_____ Work:_____ Cell:_____
Employer:_____

School Attending:_____ Grade:_____ Teacher:_____

Other children in home (please include name and age):_____

_____

Allergies:_____

Family Physician:_____ Highest grade completed:_____

Marital Status: _____Single _____Married _____Separated _____Divorced _____Other

Partner's Name:_____ Phone:_____ Religion (optional):_____

Previous counseling history:_____

_____

Medications currently taking:_____

_____

Why are you seeking help?_____

_____

_____

Referral Source:_____

Responsible Party's Insurance Information

Primary Insurance: _____ Member #:_____ Group #:_____

Name of Policy Holder:_____ Employer:_____

DOB:_____ SSN:_____ Deductible:_____ CoPay:_____ # of Sessions:_____

Secondary Insurance: _____ Member #:_____ Group #:_____

Name of Policy Holder:_____ Employer:_____

DOB:_____ SSN:_____ Deductible:_____ CoPay:_____ # of Sessions:_____

AUTHORIZATION RELEASE: I, HEREBY, AUTHORIZE THE THERAPIST TO RELEASE SUFFICIENT INFORMATION TO SETTLE ANY INSURANCE CLAIM:

SIGNATURE:_____ DATE:_____