Jill A. Selbach, Ph.D.

Licensed Clinical Psychologist

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Adult Intake

Date: _____

Full Legal Name:_____

Date of Birth:___/ ____/_____ Age: _____

Address: _____

Telephone Numbers: OK to contact?
Home: _____ /_____-_____Yes _____No_____
Work: _____ / _____ - _____Yes _____ No_____
Cellular:_____ /_____ -_____Yes _____ No_____

E-Mail address (only provide if it is OK to contact you via e-mail):

_____@_____

Highest Education Completed:_____

Occupation:_____

Religious Affiliation:_____

Children? Yes___ No____If yes, how many/ Ages? _____

Briefly describe why you are seeking services at this time: _____

Have you ever been under the care of a mental health professional before; i.e., psychiatrist, psychologist, social worker, or counselor? Yes No Are you presently under the care of a mental health professional? Yes No

If you answered yes to either of the above two questions, please briefly describe when, with whom, and for what purpose:

_____

_____

Additional Information/Comments:

_____

_____

In case of emergency, whom may I contact?_____

Telephone number: _____/ _____ - _____ Relationship to you:_____

Payment Information

Please note that payment is expected at the time services are rendered. If you are planning on using your health insurance, then please request an invoice. It is the patient's responsibility to submit claims to his/her insurance company. Please understand that Jill A. Selbach, Ph.D., Licensed Psychologist, is not a provider with your health insurance carrier. You are therefore using out-of-network benefits when seeking the services of Dr. Jill A. Selbach.

To the best of my knowledge, the information completed on this intake is accurate. By signing this form, I understand that I am agreeing with the terms outlined above.

Signature _____ **Date** _____