

Claire Ellison Counseling

Intake Form

Today's date: _____ Referred by: _____

Type of services requesting (**circle all that apply**):

Individual

Couple

Family

Play

Identifying Information

Client Name: _____ DOB: _____ M/F _____

Address: _____

City _____ Zip Code _____

Phone: _____ Alt. phone: _____ E-mail: _____

Employer/School _____

Person Responsible for Payment: Relation to Client: _____

Name: _____ DOB: _____ Age: _____ M/F: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address: _____

Employer (or school): _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip Code: _____

Spouse Name: _____ DOB: _____ Age: _____ M/F: _____

Spouse Street Address: _____ City: _____ State: _____ Zip Code: _____

Spouse Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address: _____

Employer (or school): _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip Code: _____

Insurance Information: Name of Insurance Holder: _____

Name of Insurance Company: _____

Name of Ins. Plan: (HMO/PPO) _____ Member ID: _____ Group ID: _____

Ins. Benefits Phone # for Provider: _____ Ins. Benefits Phone # for Members: _____

Ins. Claims Street Address: _____

City: _____ State: _____ Zip: _____

I give permission for Claire Ellison to contact me and my insurance company.

Client Signature

Date