# Request for Service

Request Date:_____ Screened by:_____ Date:_____

Have you ever been seen here in this practice before? No ☐ Yes ☐ Year_____

Client Legal Name:_____ DOB:_____ Age:_____

Cell#_____ Home#_____ Work#_____

Email:_____

Referred by:_____

Person Calling/Relation:_____ Phone#:_____

Address:_____

City/Town:_____ State:_____ Zip:_____

Availability for Sessions: ☐ Day ☐ Evening Day(s) of Week_____

Requested Clinician Preference: Male/Female Other Preferences: _____

Primary Insurance:_____ID#_____

Secondary Insurance: _____ ID#_____

Prior Treatment:_____

Mental Health Meds?_____

Prescriber: _____

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Members of Household

| Name | Age | Relationship | Occupation | Concerns |
|---|---|---|---|---|
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| | | | | |

Presenting Problem:_____

_____

_____

Appt Scheduled/Date & Time _____ Clinician _____

*****PLEASE REMEMBER TO PUT IN GOOGLE DOCS AFTER SCREENING CALL*****