Intake Form

Date: _____

Client Information

Full Name: _____ DOB: _____ Age: _____

Last *First* *M.I.*

Gender: _____ Race/Ethnicity: _____ Marital Status: _____

Address: _____

Street Address *Apartment/Unit #*

_____

City *State* *ZIP Code*

Phone: _____ Email: _____

Name of Spouse/Guardian: _____ Phone: _____

Address: _____

Street Address *Apartment/Unit #*

_____

City *State* *ZIP Code*

Therapist Preference: ☐Male ☐Female Therapist Location Preference: _____

(Lansing / West Lansing / East Lansing)

Availability for appointments: _____

Reason for seeking counseling: _____

Referral Information

How did you hear of our clinic (or from whom)? _____

Phone: _____ Relationship to referral source: _____

Insurance Information

Primary Insurance		Secondary Insurance	
Provider Name:		Provider Name	
Phone #:		Phone #	
Contract / ID #:		Contract / ID #	
Group / Account #:		Group / Account #	
Subscriber Name:		Subscriber Name	
Subscriber DOB:		Subscriber DOB	
Subscriber Relation:		Subscriber Relation	