

INITIAL TELEPHONE CONTACT

Full Name: _____ Date: _____ Time: _____
Street Address: _____
City/State/Zip: _____ County of Residence: _____
 Foster Care/Group Home/Nursing Home County of Origin _____
Legal Guardian: _____
Agency/Person Who Provides Background Information: _____
SS# _____ Telephone: _____ Bus. Phone: _____
Male/Female Adult/Child Date of Birth: _____ Age: _____
Annual Gross Income _____ Monthly Gross Income _____
Race: White/Black/Asian /Pacific Island/M Alaskan /Native American /Unknown
Ethnicity: E- Not Hispanic or Latino/ A- Puerto Rican/ B- Mexican/ C- Cuban/ D- Other Hispanic
Family Size: _____ Pregnant Yes / No
Marital Status: S/M/D/W Spouse Name: _____ #Children: _____

Payment Arrangements: Medicaid Medicare Self Pay Insurance See Back

Insurance Name: _____ Policy # _____

Subscriber's Name: _____ SS # _____

Employer: _____ Group # _____

Insurance Phone #: _____ Other Payment Source: _____

Deductible/Co-Pay: _____ Amount Due 1st Session: _____

Court Ordered: Yes No

Which Court: _____

Address: _____

Probation/Parole Officer: _____

Services Requested:

Counseling Type: _____

Group Which Group: _____

Assessment (see assessment intake form)

CSP: For What: _____

Medication/Somatic

Have or are you receiving mental health services from another agency in the past 12 month? Yes or No
If so where? What type of services? _____

Do we have permission to access your Medicaid Client Eligibility and Benefits Information? Yes or No

Program: General Anger Mgmt Sex Offender SAY Sexual Abuse Victim

AOD PIP Court Diversion Municipal Court Forensic Eval

Reason for Seeking Services: _____

Factors effecting client assignment _____

Urgency: Emergency (4 hours) Urgent (24 hours) Routine (7 days)

Appointment Offered (date/time): _____ Therapist: _____

Appointment Scheduled (date/time): _____ Therapist: _____

Referral Source: _____

Person Taking Intake: _____

Client Information Mailed: Yes No Client will arrive early to complete.