Emmaus Counseling Center

"We are committed to 'walking with you' and helping you to find peace in your life."

New Client Intake Form

Today's Date:______________________

Thank you for selecting **Emmaus Counseling Center**. In order to serve you properly, we will need the following information (*please print*). **All information is strictly confidential.**

Patient's Name:	Gender: M F	Patient's Birthdate:	Patient's Social Security Number:
Address: City: State: Zip:			Home Phone:
If patient is a child, what is the parent's or guardian's name?		Parent's Birthdate:	Parent's Social Security Number:
Name of Employer:			Business Phone:
Occupation:			Marital Status: Married Single Divorced
Name of Spouse:		Spouse's Birthdate:	Spouse's Social Security Number:
Spouse's Employer:			Spouse's Business Phone:

Insurance Information		For Office Use Only →	DSM IV Code
Do you have medical Insurance? Yes No	Insured through your employer? Yes No	If no, how do you intend to pay? Check Cash Credit Card	
Insurance Company:	Mental Health Claims Address:		
Subscriber's Name:	Subscriber's Number:	Subscriber's Group Number:	
Secondary Insurance? Yes No	Secondary Ins. Company:	Secondary Ins. Subscriber's Number:	Secondary Ins. Group Number:

Person financially responsible for this account:		Address:
Nearest friend of relative not residing with you:	Relationship to Patient:	Phone Number:
Whom may we thank for referring you?	Emergency Contact Name:	Emergency Contact Phone Number:

I authorize this office to release any information necessary to expedite insurance claims.
I understand that I am responsible for all charges, regardless of insurance coverage.

Patient, Parent or Guardian Signature: ____________________________________ Date: ____________________

☐ I authorize/ ☐ *do not* authorize Emmaus Counseling Center to release information to my physician.

Name of Primary Care Physician:__________________________ Clinic: ______________________________________

Health Information:

Date of Last Physical:________________ Health Problems (please list major illnesses or conditions in the last year):
____

Medications if any:

Medication	Dose	Reason for Taking

Please rate the amount of concern your problem is causing in each of the following areas by placing an “X” in the column that most closely describes it:

Symptom	1 No concern at all	2 Some concern	3 Moderate Concern	4 Serious	5 Very Serious	6 Not Applicable
Ability to sleep						
Ability to work						
Ability to concentrate						
Appetite						
Relationships						
Depression						
Thoughts of suicide						
Physical Health						
Memory loss						
Alcohol/Drug concerns						
Anxiety						

Have you had previous counseling?

☐ Yes ☐ No If yes, when, and for how long? ____

What specific event(s) or experience(s) have led you to seek counseling now?
____
____
____
____

Would you like to receive appointment reminders via email?

☐ Yes ☐ No *If yes, please provide the personal email address you would like us to use:
____

* Reminders will be sent email 1 week and then 1 day before your scheduled appointment. Please make sure to set your email program to allow emails from our HIPAA compliant scheduling provider which will show "From: DoNotReply@PracticeFusion.net" and the subject line will read "Your Appointment At Emmaus Counseling Center".