Intake Form

**ASSOCIATED COUNSELING GROUP**

♦ 748 N MAIN STREET ♦ FREMONT, NE 68025 ♦
♦ 402-941-7016 ♦

**Therapist/Counselor:** _____

_____

**Date of Intake:** **Date/Time of 1st Appointment:**

Please Print. INCOMING STATUS: □ NEW CLIENT □ PREVIOUS CLIENT

| | | | | | |
|---|---|---|---|---|---|
| LAST NAME | FIRST NAME | | MAIDEN NAME | | SOCIAL SECURITY NUMBER |
| STREET ADDRESS | CITY | STATE | ZIP | □ MALE □ FEMALE | DATE OF BIRTH |
| FULL NAME OF RESPONSIBLE PARTY AND RELATIONSHIP | | | RESPONSIBLE PARTY'S ADDRESS | | |
| HOME PHONE- OK TO CALL? □ YES □ NO | WORK PHONE- OK TO CALL? □ YES □ NO | | # PEOPLE IN HOUSHOLD? | # OF ADULTS: # OF CHILDREN: | |
| INSURANCE COMPANY NAME: | | | ELIGIBIITY PHONE NUMBER: | | |
| POLICY HOLDER'S NAME: | | | POLICY HOLDER'S SS#: | | |
| POLICY HOLDER'S GROUP #: | | | RELATIONSHIP TO CLIENT: | | |
| POLICY TYPE: □ SINGLE □ FAMILY/GROUP COPY OF INSURANCE CARD REQUESTED: □ YES □ NO | | | I give consent to Associated Counseling Group release any information needed to determine benefits under any or all insurance or government programs on: _____(date) _____ (time). □ YES □ NO | | |
| PAST HISTORY OF TREATMENT/ PREVIOUS COUNSELING/THERAPIST'S NAME | | | MEDICATIONS CURRENTLY TAKING: | PHYSICIAN: | |
| REASON FOR APPOINTMENT: | | | SPECIAL CONCERNS: | WHO WILL ATTEND THE FIRST APPOINTMENT: | |

EMPLOYER:_____
NAME ADDRESSS PHONE

HOW WERE YOU REFERED TO US: _____

NOTES: