Warren Street Family Counseling Associates, Inc.

INTAKE / REFERRAL FORM

Date: ______________________ **Client Acct. #** ______________________

Referred by: ______________________ **Referred to:** ______________________

Intake packet w/ privacy form mailed? **YES** **NO** Client gender: **Female** **Male**

Caller name: ______________________

Relationship to client: **Parent** ______________________

Minor - Name of mother: ______________________ Name of father: ______________________

Type of service caller is seeking: **Individual** ______________________

PATIENT INFORMATION

Name: ______________________ D.O.B: ______________________ Age: ______________________

Client social security number: ______________________ Employer: ______________________

Home Mailing address: ______________________ City: ______________________

State: __________ Zip code: ______________________ Address of: **mother** **father** **STEP** ______________________

Other address: ______________________ City: ______________________

State: __________ Zip code: ______________________ Address of: **mother** **father** **other:** ______________________

Home phone: ______________________ Work phone: Ext: ______________________

Cell phone: ______________________ Other phone: ______________________ Message **YES** **NO**

In case of an emergency you have my permission to contact: ______________________ Tel #: ______________________

Current medications: ______________________

Previous therapy: **YES** **NO** With whom: ______________________ Last Time: ______________________

Best times to schedule an appt: ______________________

Email address: ______________________

Client is coming to Warren Street Family Counseling because:

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First appointment scheduled for: ______________________ Time: ______________________

To be completed by the clinician

Usual service code: __________

Diagnosis code __________

Client's fee per session: __________ Is this a self pay client: **YES** **NO**