INITIAL CONTACT SUMMARY

Client First Name _____ MI _____ Last Name _____

DOB _____ SS# _____

Mailing Address _____

_____

Home # _____ Cell # _____ Message OK: Yes No Text OK: Yes No

E-Mail Address _____

Parent or Spouse _____

Person Retaining Legal Custody if not Parent (Name, Phone, Address)

_____

_____

Presenting Issue _____

Referred By _____

Primary Care Physician _____ PCP Clinic _____

Current MH Therapist/Psychiatrist _____

Type of Insurance _____

ID # _____ Group # _____

Policy Holder Info – Name _____ DOB _____

Relation to Client _____ Employer _____

Physicians, Hospitals, Mental Health Providers Seen in the Last 3 Years (Name, Facility Name, City, State)

1._____

2._____

3._____

4._____

OFFICE USE ONLY

ICS DATE _____ NEW _____ CLOSED _____ CHART # _____

APPT DATE/TIME _____ CLINICIAN _____ INTAKE DATE/TIME _____