OFFICE INTAKE FORM

CALL INFORMATION

Name of Caller:	Time of Call:	Date of Call:	Urgent: ☐ Yes ☐ No
Phone:	MEAP: ☐ Yes ☐ No	Relationship to Patient:	
Who Referred client?		Who was client referred to?	

PATIENT INFORMATION

Patient Name:	□ M □ F	Date of Birth:	Age:	Marital Status:
Patient Name:	□ M □ F	Date of Birth:	Age:	Marital Status:

MEAP EMPLOYEE INFORMATION

Employee/ Name:	□ FT □ PT	Secure Phone:	Relationship to Patient:
Employer:	Department/Location:	Position:	

INSURANCE INFORMATION

Policy Holder Name:	Date of Birth:	Social Security No:
Mailing Address:		Phone:
City:	State:	Zip Code:
Primary Insurance Company:		Policy/Member No:
Secondary Insurance Company:		Policy/Member No:

PRESENTING PROBLEM

☐ Drugs/Alcohol ☐ Depression ☐ Parenting/Children ☐ Job Stress/Burnout
☐ Eating Disorder ☐ Stress/Anxiety ☐ Sleeping Problems ☐ Post-Traumatic Stress
☐ Physical Health ☐ Anger Issues ☐ Bereavement/Grief ☐ Marriage/Relationship
Other: _____

Call Taken By:	Appointment Date: 24 hr. cxl policy ___	Appointment Time:	Counselor:	Database (Intl. and Date):

Additional Comments:

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