RIVER COVE COUNSELING

INTAKE FORM

Date: _____

PERSONAL INFORMATION:

Name: _____

(Last) (First) (Middle Initial)

Address: _____

Street (Apt or Unit #) Town/City Zip Code

Birth Date: _____

Contact Number(s): _____ ☐ Home ☐ Mobile ☐ Work

_____ ☐ Home ☐ Mobile ☐ Work_____

May I leave a message? ☐ Yes; (___) _____-_____ ☐ No

E-mail: _____

May I e-mail you? ☐ Yes at _____ ☐ No

**Signature allowing contact:* _____

Emergency Contact:

Name_____ Relation _____ Phone _____

Referred By:

INSURANCE INFORMATION:

Insurance Company _____

Policy Holder (if not you, your relation to Policy Holder) _____

Birth Date of Policy Holder _____

Employer of Policy Holder _____

Address: _____

Street (Apt or Unit #) Town/City Zip Code

Policy Number_____ Group Number_____ CoPay $ _____

☐ HMO ☐ PPO ☐ Other _____ ☐ I have no idea ☺

Is preauthorization needed? _____ If so, how many visits have been authorized?_____

Do I have permission to discuss finances with the Policy Holder if other than you? ☐ Yes ☐ No

Please note: If preauthorization is required by your insurance company(s) and has not been done, you will be responsible for payment, in full, at your initial visit and subsequent visits. Thank you.

ADDITIONAL INFORMATION:

Have you previously seen a therapist? ☐ Yes ☐ No

Have you previously seen a therapist for substance use dependency? ☐ Yes ☐ No

If needed, may I contact that therapist for coordination of care? ☐ Yes ☐ No

Name of therapist: _____

If "yes" we will sign a release of information at our third session.

Are you currently taking prescribed psychiatric medication (antidepressants, MAT, or others)?

☐ Yes ☐ No

If "yes" please list below including prescriber and contact number:

Rx _____ dose _____ x day _____

Rx _____ dose _____ x day _____

Rx _____ dose _____ x day _____

Name of Prescriber & Phone Number: _____

Are you currently taking prescribed medication for health reasons? (Hypertension, chronic pain, etc)

Rx _____ dose _____ x day _____

Rx _____ dose _____ x day _____

Rx _____ dose _____ x day _____

Name of Prescriber and Phone Number: _____

If needed, may I contact that therapist for coordination of care? ☐ Yes ☐ No

If "yes" we will sign a release of information at our third session.

Have you ever been hospitalized for any reason? (Medical or otherwise) ☐ Yes ☐ No

Please give dates and short explanation _____

_____

_____

_____