COOKS COUNSELING

'WHERE YOU CAN FIND HOPE AND HEALING'

Clinical Intake Form

Full Name ________________________________ Nickname ____________________

Date of Birth __________________ Address ________________________________
City __________________ TX ZIP ____________

Email address ____

Phone Number ______________________

Can we leave a voicemail? Y N Can we text? Y N Can you receive mail at address? Y N

How would you like to be reminded for appointments? (Circle one)

Text Phone Call Email No reminder

Marital Status (Circle one)

Single Married Divorced Widowed Other ____________

Who should I contact in case of emergency?

Name __________________ Relationship __________________ Phone Number ______________

Insurance Subscriber Name __________________ DOB __________ SSN ______________

Relationship to Patient ____________ Subscriber's place of Employment ______________________

Insurance:(BCBS, Aetna, Optum, Cigna, etc) ______________ Phone number ______________

Member ID ____________________ Group Number ____________________

Who is responsible for payment? __________________________ Address of Subscriber(if different from above) ______________________________ City: ______________ State: ______ Zip __________

CREDIT CARD MUST BE ON FILE- INFORMATION WILL BE ACQUIRE AT INITIAL SESSION.

EAP Auth. Number ____________ EAP: (BCBS, Aetna, Cigna, Optum, etc) ______________________

Number of Sessions ________ Phone Number for EAP __________________________

--FOR CLIENTS UNDER THE AGE OF 18--

If identified client is under 18 years of age, please add parent(s) names and contact information. If over the age of 18, please leave blank.

Parent Name ____________________________ Date of Birth ____________________

Address __________________________ City ________________ St. ______ Zip __________

Email address ____________________________ Phone ______________________________

Can we leave a voicemail? ____________ Can we text? ____________________

Parent Name ____________________________ Date of Birth ____________________

Address __________________________ City ________________ St. ______ Zip __________

Email address ____________________________ Phone ______________________________

Can we leave a voicemail? ____________ Can we text? ____________________

Please describe the custody agreement if parents are divorced. COPY OF LEGAL CONSERVATORSHIP/GUARDIANSHIP HAS TO BE PROVIDED PRIOR TO APPT. OR CLIENT WILL NOT BE SEEN.

---------------------------CONTINUE WITH CLIENT INFORMATION---------------------------

Employer ______

Name of School/ Highest Grade Completed ______

Primary Care Physician ______

Psychiatrist ______

Current medications and reason for meds? Please provide name and dosage. Attach sheet if needed.

Please describe significant health issues.

How much alcohol/ drugs do you consume on a weekly basis?

Prior counseling? Yes No If yes, with whom and when? If less than 7 years, I will request a release of information be signed.

What would you identify as your main complaint or presenting concern?

Please list additional household members, their relationship to client, age, and whether or not they will participate in sessions.

Name	Relationship to Client	Age	Will they participate in sessions?

I certify that the above information is accurate and complete to the best of my ability.

Signature ______ Date ______