Goddard Psychological Services
Robert Goddard, Ph.D.
Licensed Psychologist

INTAKE INFORMATION

CLIENT DATA:

Name: _____ Date _____

Date of Birth: _____ Age: _____ Marital Status: _____

Social Security #: _____

Referred by: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone # (home): _____ (work) _____

Mailing Address (if different from above): _____

_____

Employer (of client or parent/guardian if client is a minor): _____

_____

Occupation: _____ Work Phone #: _____

FINANCIAL DATA:

Party responsible for financial arrangements: _____

Client relationship to responsible party: _____

Billing address (if different from above): _____

Primary Insurance Company Name: _____

Subscriber: _____ DOB: _____Certificate #: _____

Subscriber's Address: _____ Phone #: _____

City: _____ State: _____ Zip: _____

Secondary Insurance Company Name: _____

Subscriber: _____ DOB: _____Certificate #: _____

Subscriber's Address: _____ Phone #: _____

City: _____ State: _____ Zip: _____

FAMILY DATA:

Household members (with whom client lives) – Please use back if needed.

Name _____ Relationship _____ DOB: _____

Name _____ Relationship _____ DOB: _____

Name _____ Relationship _____ DOB: _____

Name _____ Relationship _____ DOB: _____

COUNSELING HISTORY:

Has client been in psychotherapy/counseling before? _____

If so, when? _____ Where? _____

MEDICAL HISTORY:

Please list significant medical issues that you may be currently dealing with _____

_____

Medications: Please list any medications you are currently taking.

Prescribing Physician: _____ PCP: _____

Medication: _____ Dosage: _____
_____ _____
_____ _____

For office use only:
Insurance Verification:
Payment _____ Deductible _____ Co-payment _____
Special requirements for payment (for example, pre-authorization, primary care physician form, limited number of sessions per year….):
_____
_____
_____

Sliding Fee Scale: If client has no insurance, or chooses to not use insurance, the following sliding fee scale, payable at each session, has been agreed upon: _____

Diagnostic Information: DSM-V / ICD-10
Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: Current: _____ Last Year: _____