Thriving Families Counseling Services
2213 Grand Avenue
Des Moines, IA 50312
P: 515-808-2900
F: 515-462-0504
www.thrivingfamiliesservices.com

Intake Form

Name: ______________________________ DOB: ____________ Age: _____ Gender: ________

Race/ Nationality: ______________________ Marital Status: Single/ Cohabitaing/ Married/ Divorced/ Widowed

Address: ____________________________ City/ State: __________________ ZIP: ___________

Phone: ____________________ Email: ______________________________

Please check the following if TFCS staff may:
____ contact you or leave messages at your phone number
____ contact you by text messages
____ contact you by email

Described reason(s) for seeking services at this time: ____________________________________

____

____

BIOMEDICAL/ PSYCHOLOGICAL HISTORY

Medical issues or concerns/ allergies: ____

____

Primary Care Physician/ Hospital: ____

Last PCP appt: ______________ Last vision appt: ______________ Last hearing appt: ______________

Psychological diagnoses: ____

History of previous therapy/ psychiatry? Yes No Where? _______________________________

List of current medications: ____

____

SOCIAL HISTORY

Employer: ____________________________ Job Title: _________________________

School: __________________ Year in School: ___________ OR Year completed: __________

Current Court involvement? Yes No Involved with DHS? Yes No

Probation Officer: _______________________ DHS worker: ______________________

LIST # OF PEOPLE IN CLIENT'S HOME CURRENTLY:

NAME	AGE	RELATIONSHIP TO CLIENT

IN CASE OF EMERGENCY, CONTACT:

Name: ______________________________ Realationship to client: ______________________________

Address: ______________________________ City/ State: ____________________ ZIP: ____________

Phone: ____________________ Email: ______________________________

Insurance & Payment Information

_____ I will be personally responsible and privately paying for charges of treatment.
_____ I will be paying for treatment with my insurance. (**PLEASE COMPLETE THE FOLLOWING INFORMATION ON INSURANCE)**

Primary Insurance Company: Secondary Insurance Company:

Company Name:	Company Name:
Subscriber Name:	Subscriber Name:
Subscriber Birthdate:	Subscriber Birthdate:
Relationship to client:	Relationship to client:
Policy #:	Policy #:
Group #:	Group #:
Co-payment: $	Co-payment: $

Insurance Payment Authorization
I hereby direct my insurers to pay directly to Thriving Families Counseling Services and/or my therapist all benefits due to them as a result of my claims for my treatment. Although covered by insurance, I am aware that I am personally responsible for all charges. A photocopy of this authorization will be as valid as the original.

Signature: ______________________________ Date: ____________

Insurance Release of Information Authorization
I hereby authorize Thriving Families Counseling Services and/or my therapist to release information concerning my present illness to insurance carrier for the purpose of processing my claims. I understand that if this is not signed, I must pay for services in full. A photocopy of this authorization will be as valid as the original.

Signature: ______________________________ Date: ____________