Tim F. Fitsimones, M.A., LMHC, CAP

Professional Counseling Services
P.O. Box 82
Winter Park, FL 32790

Ph. 407-629-7114
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Licensed Mental Health Counselor
Certified Addictions Professional

INTAKE ASSESSMENT

NAME:	SOC.SEC. #	SEX M ☐ F ☐	DOB	AGE
ADDRESS:		Home Ph: ( ) Work Ph : ( ) Cell or Pager: ( )		
CITY - STATE - ZIP		Marital Status: ☑ Divorced ☐ Single ☐ Widowed ☐ Committed Relationship ☐ Married ☐ Separated		
NAME OF INSURED	INSURED SOC. SEC. #	INSURED DOB	YOUR RELATIONSHIP TO INSURED: self ☐ spouse ☐ child ☐ other ☐	
PRIMARY INSURANCE COMPANY I.D.#	GROUP #	PLAN #	AUTHORIZATION #	
INSURANCE COMPANY ADDRESS	CITY – STATE - ZIP		PHONE NO.	
EMPLOYER OCCUPATION Supervisor's name:	HIGHEST GRADE IN SCHOOL	Do you think that alcohol is harmful to your health ? Yes ☐ No ☐ Do you think that tobacco is harmful to your health ? Yes ☐ No ☐ Do you think that drugs are harmful to your health ? Yes ☐ No ☐		
HAVE YOU BEEN IN THERAPY PREVIOUSLY? YES ☐ NO ☐	If yes please list name of therapist and date			
CREDIT CARD INFORMATION CREDIT CARD COMPANY NAME		EXPIRATION DATE	CVV	
NAME AS IT APPEARS ON CARD		DO WE HAVE PERMISSION TO CHARGE TO THIS ACCOUNT?		
PLEASE DESCRIBE THE PROBLEM(S) THAT BRING YOU TO THERAPY:				
E-Mail address: Work: Home: Do we have permission to contact you with emailings?		(For Therapist use Only) Diagnosis		

LATE CANCELLATIONS & MISSED APPOINTMENTS

I agree to provide 48 hr notice of cancellation for any appointments that I have made. If I do not provide this notice, I agree that I am responsible for payment for the time I reserved and prevented others from being able to use.

_____ Signed

_____ Date