Relationship ReDiscovery Center: Intake Data Form

PLEASE PRINT CLEARLY. THANK YOU.
If seeking services as a couple please complete a form for each of you.

Today's Date:

Date of Birth:

Client's First Name:	Middle	Last Name:
_____ Female _____ Male	__Single __Married __ Partnered __Separated __Divorced __Engaged	

Cell Phone (inc area code)

Is it okay to leave detailed messages? ____YES ____NO
Is text ok (nonconfidential info only) ____YES ____NO
Is it ok to send automated appt reminders? ____YES ____NO

Home Phone:	Work Phone: (Optional)
Is it okay to call you at this number? ____YES ____NO Is it okay to leave detailed messages? ____YES ____NO	Is it okay to call you at this number? ____YES ____NO Is it okay to leave detailed messages? ____YES ____NO

Email Address:

Street / P.O. Address:

City:	State / Zip:
Have you called your insurance company for preauthorization: yes no	__Employed __Student __Disabled __Unemployed

Primary Care Provider	Date of last Physical:
Provider Name:	Provider Address:
Provider Phone :	Provider City / State/zip:

Psychiatric Med Manager	Date last seen:
Provider Name: Dr	Provider Address:
Provider Phone:	Provider City / State/zip:

Current medical Issues / illness:

Current Medication	Purpose	Dosage	Prescribed by:

Allergies:

List any know medical emergency which could occur during a session:

Who referred you? How did you hear about the services here?

If you are using your medical insurance please submit a copy, front and back, of your card. Thank You