MICHAEL RILEY COUNSELING

Phone: 417-597-3572 E-mail: michael@michaelrileycounseling.com

Intake Information

Date_____________

Client Name___________________________________

Guardian Name (if client is a minor)____

Email____

Phone (Cell)___________________ Carrier________________ Home Phone_________________

Address
Street/Apt #________________________ City________________ State________ Zip__________

Client DOB____________________

Insurance Type (Medicaid, Private, etc)_____________________

Insurance ID______________________ Insurance DCN______________________

Service Requested (Individual, Family, Assessment, etc)_________________________________

Best Days/Times (list up to three days/times, if possible)

1.______________________________________

2.______________________________________

3.______________________________________

In Home/Telehealth/Other Office (as available)___________________________

Who may we thank for referring you?___________________________________

Children's Division Involvement? YES NO

County____________________ Worker's Name______________________

Phone_____________________ Email_______________________________

Issues to be addressed

Appointment Date______________________________