

Total One Resources

PSYCHOTHERAPY INTAKE FORM

23300 Greenfield Road, Suite 122 - Oak Park, MI 48237

Office: 248 968-9608 ■ Fax: 248 968-9516

Referral Date: _____

DOB: ____/____/____

Name of Client: _____ Sex : Male ☐ Female ☐

Medicare Information: _____ (Please attach copies of cards)

Policy#:_____ Group#:_____ Other Insurance:_____

Address:_____ City:_____ MI, Zip:_____

Home Phone: _____ Cell Phone: _____

Insurance Information

Check all that Apply:

- ☐ Depression ☐ Anxiety ☐ Stress ☐ Drug Abuse ☐ Divorced
☐ Loss of Loves One ☐ Lack of Coping/Life Skills ☐ Other: _____

Initial Evaluation: _____

Diagnosis (If known): _____

Active Medication (If applicable) _____

List All Medications: _____

Referring Physician/NP/PA:_____ Date:_____

Referring Agency:_____ Phone#:_____

Address: _____

Thank you in advance for your referral