

Mindock Counseling and Consulting
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CLIENT INTAKE FORM

(Please Print)

Today's Date ____/____/____

Therapist _____

CLIENT INFORMATION

Client's Last Name			First	Middle	Marital Status (Circle One) Single / Married / Other / Divorced	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former Name)		Birth Date / /	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Address		City	State	ZIP Code	Cell Phone No. ()	
Occupation	Employer			Work Phone No. ()		
Referred to Provider by (Please check one box & list) <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Close to Home/Work				<input type="checkbox"/> Dr. _____	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Website
				<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other _____	
Email Address:				Alternative Email Address:		

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No.	Work Phone No.

PLEASE READ THE FOLLOWING CAREFULLY

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. Note- for EAP services, please provide authorized billing number.

X _____
CLIENT/GUARDIAN SIGNATURE DATE

I hereby consent to treatment by specified provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.

X _____
CLIENT/GUARDIAN SIGNATURE DATE

