MARGARET MOSS LEVY, LCSW, CPC

INITIAL INTERVIEW FORM

Date:_____

CLIENT INFORMATION:

Name:_____
Phone: (Cell)_____(Home)_____
Email: _____
Address:_____City:_____
State:_____Zip:_____
Sex: _____ Date of Birth:_____
Others living at home: list name, relationship to client, age, and occupation of those others living at home

Employer/School:_____ Occupation/Grade:_____
How long have you worked there?_____How long in this occupation?_____
Education: (List highest level of education attained)_____
Primary Physician:_____Phone:_____
List any significant health problems:_____
_____
_____
List any medications you are taking and the dosage:_____
_____
Have you seen this type of therapist before? YES___NO_____
If yes, when and with whom?_____
Give a brief description of treatment:_____
_____
How were you referred to our office?_____
Who may we thank for referring you?_____
Nearest relative other than spouse:_____

FINANCIALLY RESPONSIBLE PERSON'S INFORMATION:

Name:_____ Relationship to Client:_____
Phone (if different from above):_____
Address (if different from above):_____
Insurance Carrier (if applicable):_____
Social Security Number of Insured:_____
Group Number:_____ Member Number:_____
Insurance Phone Number:_____