Reclaim Life Therapy PLLC
Intake Form

Date of Intake _____ Referral from:_____

Caller's Name _____ Caller's Number _____

Client Information

Name _____ male/female _____

Address _____
Street City State Zip

Telephone home_____ cell_____work _____

Date of Birth _____Age_____

Education Highest grade_____ Degree (if applicable)_____

Emergency Contact _____ Relationship _____ Phone _____

Marital status _____(Married Single Separated Divorced Widow) **Years** (if appl) _____

Spouse Name _____DOB _____ Occupation_____

Client Occupation (current or past) _____

Primary Care Physician _____ Phone _____last visit _____

Medical History: (specify major problems, accidents, hospitalizations, current medication)

_____

Past/present drug/alcohol use/abuse (any addiction, Treatment: AA/NA)

_____

Family history of alcoholism, mental illness, violence, suicide

_____

Presenting problem _____

_____

Insurance

Primary Company_____Policy No._____

Group No. (if applicable)_____

Secondary Company_____Policy No._____

Group No. (if applicable)_____

If out of network, patient willing to pay increased amount? ☐Yes ☐ No