# Intake Form

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Mobile Phone _____

Email _____ Okay to Use? ☐ Yes ☐ No

Date of Birth _____ Age _____

Referred for Counseling by _____

May I contact them to acknowledge the referral? ☐ Yes ☐ No

Primary Physician _____ Phone _____

Emergency Contact _____ Phone _____

Current Relationship Status _____ How Long? _____

*(single, married, etc.)*

Which of you will be the primary scheduling and billing contact?

List your children, if any, and their ages:

List your parents and siblings, with their ages or date of death:

What medications are you currently taking?

Have you had any significant losses in the past few years?

Have you and/or anyone in your family had any of these problems? Please check all that apply.

| | Self | Family | Comments |
|---|---|---|---|
| Alcohol Abuse | | | |
| Drug Abuse | | | |
| Obesity | | | |
| Eating Problems | | | |
| Depression | | | |
| Other Mental Health Problems | | | |
| Suicidal Thoughts, Attempts or Completions | | | |
| Other | | | |

Have you previously undergone any counseling or psychiatric care? _____
If so, please describe:

If we are successful in our work together, what outcome(s) are you seeking?

Please initial your aggrement to the following:

_____ I understand I will be charged my session fee if I cancel with less than 48 hours' notice.

_____ I understand Dr. Raab-Cohen does not offer emergency coverage after 10 p.m. In the event of an emergency, please call 911.

_____ I understand that email may not be secure and should be used primarily for scheduling.

Signing this form constitutes an agreement that you have read and received the Office Policies Statement and the Notice of Privacy Practices. You have asked for any clarification needed and accept the terms. You also agree to accept responsibility for paying my fee according to the conditions in the Statement.

Signature _____

Date Signed _____