Hope for Recovery of D'Amico & Associates in Counseling

Client Intake

Date: _____/_____/_____

Client Name:_____ DOB:_____/_____/_____

Parent/Guardian Name (if under 18 years old):_____

Street Address (include apt/unit # if applicable):_____

City:_____ State:_____ Zip Code:_____

Cell Phone: (____)_____-_____ Work Phone: (_____)_____-_____

Home Phone (if available): (____)_____-_____

Email address:_____

Emergency Contact Name:_____

Relationship to Client:_____ Phone:(____)_____-_____

Name of Party Responsible for Payment:_____

Phone (if someone other than yourself): (____)_____-_____

Address (if someone other than yourself):_____

City:_____ State:_____ Zip Code:_____

Referral Source:_____

Previous Treatment/Therapy:_____

_____

Do you have a physical or medical disability? (Circle one): YES NO

If YES, please describe:_____

(Complete if applicable)

Attorney Name:_____

Phone: (____)_____-_____ Fax: (____)_____-_____

Address:_____

COORDINATION OF TREAMENT: It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization. If you prefer to decline consent no information will be shared.

____You may inform my physician(s) ____I decline consent to inform my physician(s)

Physician Name:_____

Name of Clinic:_____

Adress:_____

Phone: (____)_____-_____ Fax: (____)_____-_____

Date of last physical exam: _____/_____/_____

Signature:_____ Date: _____/_____/_____