

ADULT INTAKE

Date:

1. Name: First _____
Middle Initial _____
Last _____

2. Address: _____

Zip Code _____

3. Home Telephone: _____

4. Business Telephone: _____

5. Cell/Mobile Telephone: _____

6. Social Security (if using insurance): _ _ _ - _ _ - _ _ _ _

7. Birth Date: (month) (day) (year): _ _ / _ _ / _ _ _ _ /

8. Age: _____

9. Single ___ Married ___ Divorced ___ Living Together ___

10. How many times married? None ___ One ___ Two ___ Three or more ___

***If using Insurance ALL items below must be completed.
Skip to Question # 20 if self-pay or filing on your own)**

11. Name of insurance company:

12. Insured's ID (exactly as shown on the card):

13. Name of the INSURED (if same as client, write "same")

14. Client Relationship to Insured: (circle one)

Self Spouse Child Other

15 . Insured's Policy number (refer to insurance card):

16. Insured's Date of Birth:

(month) (day) (year): __/__/____/

17. Employer's Name:_____

18. Insurance Plan Name (from insurance card):_____

19. Is there another health plan? Yes__ No__

20. Education(last grade completed)_____

21. Degree Earned:_____

22. Occupation:_____

23. Number of Children: 0 1 2 3 4 5 6 +__

24. Ages of children: __ __ __ __ __ __ __

25. How many live at home?_____

26. Parents: Both parents alive? Yes__ No__

How far do you live from your parents?_____

27. Are you currently under a physician's care?

Yes_____ Physician's Name:_____

What are you being treated for?_____

What medications are you taking?_____

28. Alcohol consumed per week:

_____# of glasses of _____.

_____I do not drink alcohol.

29. Recreational Drug Use:

None__ Daily__ Weekly__ Monthly__ Once in a while__

Type of drug/preferred drug:_____

30. Does/Did anyone in your family have a substance abuse problem? If YES, Specify person and substance_____

31. Previous therapy or counseling? If YES, for what?_____

32. What do you want to see change in yourself? (What brings you here?)

33. What do you want to see change in your relationship/family?

34. I AUTHORIZE the release of medical information necessary to process this claim. YES__

35. I AUTHORIZE payment of medical benefits to Dr. Elizanda M. de la Sota. YES__

36. I understand that all charges are due at the time that services are rendered. Scheduled appointments which are cancelled with less than 24 hours notice incur the FULL SESSION CHARGE of \$150.00. (Insurance does not pay for any part of a missed session. You are fully responsible for the total session amount, NOT just the copay.) YES__

37. I ACCEPT financial responsibility for this account. Yes__

Signature of Responsible Adult:_____