

MARY PEACOCK, L.M.S.W., A.C.S.W.
9 HERITAGE OAK LANE, SUITE 9
BATTLE CREEK, MI 49015

CONFIDENTIAL INTAKE FORM

Date: _____

Client Name: _____ Referred by: _____

Date of birth: _____ Age: ____ Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ May therapist call you at home? _____

Employer: _____ Address: _____

Working hours: _____ Your position: _____

Work telephone: _____ May therapist call you at work? _____

Insurance Company: _____ Insurance ID# _____

Name of Insured if different: _____

Policy Holder's Social Security Number: _____

Policy Holder's Date of Birth _____

Circle those which apply: single married separated divorced widowed

If married, spouse's name: _____ Previous marriages? ____

List other family members/persons living at home:

Name: _____ Age: _____ Relationship: _____

Emergency contact person: _____

Home phone: _____ Work phone: _____ Relationship to you: _____

Have you had previous counseling, psychotherapy or psychiatric treatment? _____

If so, please provide the following information:

Therapist: _____ Dates: _____ Location: _____

Please describe your current problem or concerns: _____

Do you consider your present problems/concerns {circle one):

Mild Moderate Moderately severe Severe A Crisis

How long have your current problems/concerns existed? _____

Physician Name and Address: _____

Do you presently have any significant health problems/concerns? _____

Do you use any medications? _____ If so, please name all medications and dose: _____

Signature _____