Metro Counseling Center

Healing the Brokenhearted

INTAKE INFORMATION **Todays Date: _____**

Patient's Name: _____ Date of Birth _____

Adult's Name _____ Relation to Patient: _____

Address_____

Street City State Zip

Phone with Area Code: Home _____ Ok to leave message on an answering machine? _____

Cell _____ Ok to leave voice mail message? _____

Work _____ Ok to contact you/leave message? _____

Personal Email: _____ Okay to email to this address? _____

Employer _____

Work Email: _____ Okay to send mail to this address? _____

Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ If married, date married _____

Spouse's/Partner's Name _____ Date of Birth _____

Address _____

Street City State Zip

Employer _____

Phone with Area Code: Home _____ Ok to leave message? _____

Cell _____ Ok to leave voice mail message? _____

Work _____ Ok to contact you/leave message? _____

Please list additional family members living with you:

	Name	Relationship	Date of Birth	Employer/School
1.				
2.				
3.				

Physician _____

Name Address Phone #

Parent DOB_____ SS# _____ Payment Method _____

Credit/Debit Card # to be retained on file: _____ Zip Code with card _____

CVS # on back: _____ Expiration Date: _____ Name on Card: _____

Name of Referral Source:_____

I agree to allow my therapist to inform my referral source that I have attended an initial session

Yes _____ No _____ Signature _____

Revised 12/21/2015