JoyUnlimited
COUNSELING CENTER

Intake Form

CLIENT INFORMATION

Last Name:_______________________________ **First Name:**__________________________

DOB:________________ **SSN:**_______-_____-_________

Sex: Female______ Male______ "Other"________

Marital Status: Single______ Married______ Widowed_____ Divorced______Separated____

If under 18, Legal Guardians:

Name(s)____

CONTACT INFORMATION

Address:____

City:______________ **State:**________ **Zip Code:**______________

Phone Number:___________________________ **OK to Call?:** Y/N

Email:____________________________________

INSURANCE INFORMATION

Insurance Company:____________________________________ **Co-Pay $:**______________

SSN:_______-_____-_________ **DOB:**_________________

Subscriber Name:__________________________

Employer:_______________________ **Relationship to Client:**________________________

Group Plan #:_____________________ **Member ID:**__________________________________

THERAPY INFORMATION

Therapist Requested:____

Availability:____

Reason For Seeking Counseling:

____

____

Referral Source (Friend, coworker, pastor, etc.):________________________________

FOR ADMIN USE ONLY

Intake Assessment: Mailed___________ Emailed___________

Appointment Time Scheduled: Day___________ Time____________ Therapist___________

Intake Assessment Sent?: ☐

Therapist Chart Made?: ☐

Entered on Ref Tracker?: ☐

Entered in EMR Calendar?: ☐