South Point Counseling

32 North Main Street
Suite 214
Belmont, NC 28012
Phone: 704-825-9696 Fax: 1-866-880-8347

INITIAL VISIT INTAKE FORM

(Complete ALL Sections)

DATE: ______________ **REFERRED BY:** ____________________________________

PATIENT INFORMATION:

NAME ***(as it appears on your insurance card)*****:** ____

DATE OF BIRTH: ________________ **AGE:** ________________ **SSN:** ________________

FULL HOME ADDRESS: ______________________________________
(Street; Apt.)

____
(City, Zip Code)

TELEPHONE NUMBERS: (C/H) ______________________________ **(W)** ______________

MARITAL STATUS: ___ **SINGLE** ___ **MARRIED** ___ **SEPERATED** ___ **N/A**

RELATION TO INSURER: _____ **SELF** _____ **SPOUSE** _____ **DEPENDENT**

EMPLOYED: ___ **YES** ___ **NO** ___ **N/A**

EMAIL ADDRESS: ____

EMERGENCY CONTACT: ___________________________ **PHONE:** __________

PREVIOUS COUNSELING/HOSPITALIZATION: ____

PRIMARY CARE PHYSICIAN: ____

PHYSICAL/MEDICAL CONDITIONS: ____

CHECK ANY CONCERNS THAT APPLY TO YOU

___ DEPRESSION	___ SHAME	___ WORRY	___ SELF-DOUBT
___ ANXIETY	___ ANGER	___ MARITAL RELATIONSHIPS	___ PARENTING
___ SEXUAL	___ GRIEF/LOSS	___ OTHER RELATIONSHIPS	___ DRUG/ALCOHOL USE
___ FEAR	___ ABUSE	___ SUICIDAL THOUGHTS	___ GAMBLING
___ GUILT	___ ADHD/ADD	___ HOMICIDAL THOUGHTS	

____ OTHER CONCERNS:

WHAT HAVE YOU DONE TO RESOLVE THE ISSUE(S)?

____

____

____

____

WHAT ARE YOUR GOALS FROM COUNSELING?

1. ____
2. ____
3. ____
4. ____

INSURANCE INFORMATION:

PRIMARY INSURANCE COMPANY: ____

POLICY/ID #: ______________________________ GROUP/PLAN #: ______________

SECONDARY INSURANCE COMPANY: ____

POLICY/ID #: ______________________________ GROUP/PLAN #: ______________

INSURED/POLICY HOLDER INSURANCE INFORMATION:

NAME & ADDRESS: ____

____

SSN: ____________________ DOB: ____________ HOME PHONE #: ____________

RELATION TO CLIENT: _____ SELF _____ SPOUSE _____ DEPENDENT

EMPLOYER AND ADDRESS: ______________________________

____

____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS. IN ADDITION, I AUTHORIZE PAYMENT OF BENEFITS TO SOUTH POINT COUNSELING.

______________________________ ______________

SIGNATURE OF PATIENT DATE

(OR Legally Responsible Person/Personal Representative if Required & Relationship to Patient)

HAVE YOU COMPLETED ALL SECTIONS?

Office Use Only

DX: ____________