Cindi Bockwitz, LPC, CPCS, RPT-S www.clbockwitz.com

CLIENT INTAKE FORM

Primary Client: _____ Gender:_____ DOB:_____
Current/Highest Level of Educ:_____ School: _____
504C, IEP, or TAG?____ Implementation Date:_____ Eligibility Classification:_____
Pediatrician (if applicable):_____
If client is a minor & parents are divorced, who is the primary legal custodian?_____
Copy of custody/legal guardianship order provided? (if applicable) YES NO N/A

FAMILY INFORMATION

Parent/Guardian:_____ DOB:_____

Parent/Guardian:_____ DOB:_____

Other family/_____ Relationship:_____ DOB:_____

people in home _____ Relationship: DOB:_____

CLIENT (OR PARENT/GUARDIAN) CONTACT INFORMATION

Primary address:_____ Home phone:_____

_____ Mobile phone:_____

Employer:_____ Occupation:_____

_____ Work phone:_____

Email address:_____ Other phone:_____

OK to contact you at the numbers listed? YES NO (list)_____
OK to send account statements/communications electronically? YES NO
How were you referred? May I thank them? YES NO

CURRENT MEDICATIONS/MEDICAL ISSUES OF PRIMARY CLIENT

PAST OR CURRENT PSYCHOTHERAPY OF PRIMARY CLIENT

Any suicidal thoughts, attempts, or other self-harm behaviors in last 30 days? (circle which apply)

AUTHORIZATION & ACKNOWLEDGEMENT OF DISCLOSURE STATEMENT/EAP STATEMENT

____ I (a) verify that this information is correct, (b) assume responsibility for payment of services (including those not covered by my insurance), and (c) authorize Cindi Bockwitz to provide EAP/ counseling/therapeutic services/play therapy for ___ me ___ and/or my child.

____ I have received/read the Informed Consent Document or EAP Statement of Understanding (circle)

Insurance Co:_____ PPO/HMO/POS/Pathways/Other Member ID#_____
Insured's Name (on policy)_____ ***Insured's*** DOB:_____
Deductible per year:_____ Deductible amount:_____ Copay/Co-insurance amount:_____
Signature:_____ Date:_____

Email a copy of the front & back of insurance card so that coverage can be verified before 1st appt.

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