

Maine Counseling & Consultation LLC

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Client Intake Information

NAME _____ EMAIL: _____

DATE OF BIRTH ___/___/___ CURRENT AGE _____ S.S. # _____

ADDRESS _____

MAILING ADDRESS _____

TELEPHONE: HOME _____ WORK _____ CELL: _____

OCCUPATION _____ EMPLOYER _____

EMPLOYER'S ADDRESS _____ How Long _____

YOUR PHYSICIAN/OR PROVIDER _____

ADDRESS _____ TELEPHONE _____

LAST PHYSICAL EXAM _____

MARITAL STATUS ___single ___married ___separated ___divorced ___widowed___ committed
relationship How Long _____

SPOUSE or SIGNIFICANT OTHER'S NAME _____ DATE OF BIRTH ___/___/___

PHONE NUMBER _____ SPOUSE OR SIG/ OTHER'S OCCUPATION _____

EMPLOYER _____ HOW LONG _____

REFERRED BY _____

IN CASE OF EMERGENCY CALL _____ TELEPHONE _____

HAVE YOU BEEN IN THERAPY? _____ IF YES, PLEASE GIVE NAME(S) OF THERAPIST(S)

CURRENT MEDICAL PROBLEMS _____

ALLERGIES: _____

PAST MEDICAL PROBLEMS/HOSPITALIZATIONS

NAME _____ DATE _____

CURRENT MEDICATIONS & OTC: (VITAMINS SUPPLEMENTS, HERBS, ALLERGY SLEEP AIDS, ETC.) _____

RECENTLY DISCONTINUED MEDICATION & OTC: (VITAMINS SUPPLEMENTS, HERBS, ALLERGY SLEEP AIDS, ETC.): _____

DO YOU HAVE CHRONIC PAIN OR ANXIETY: (HEAD, CHEST, STOMACH, JOINTS, MUSCLES) _____

IF YES MEASURE 0 TO 10 (0 IS NEUTRAL) _____ HOW LONG _____

What brings you here today? : _____

What are your goals and/or your expectations? : _____

At the end of therapy, what would have changed? How would you be? What would be different in your life? _____

INSURANCE INFORMATION

Subscriber's Name: _____ Insurance Company _____

Insurance Address _____ Subscriber's SS# _____

Subscriber's date of birth _____

CERTIFICATE or I.D.# _____ GROUP # _____

1. I authorize use of this form on all my insurance submissions.
2. I authorize direct payment to Linda Taillon, LCPC and/or Leo P. Taillon, LCSW
3. I authorize the release of information to my insurance company for the services provided.
4. I permit a copy of this to be used in place of an original.

Print Name

Signature

Date

If Minor: Authorized Signature: _____