

COUNSELING LAS CRUCES

Adult Patient Intake Form

Please complete this form

PLEASE USE INK

Today's Date: _____

How did you hear about us?

Web _____ Doctor _____ Friend _____ Other _____

Information about You

Name: _____ Social Security # _____ - _____ - _____

Date of Birth: _____ - _____ - _____ Age: _____

Sex: Male _____ Female _____ MTF _____ FTM _____ Other _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address _____

Occupation: _____ Employer: _____

Marital Status: Single __ Married __ Divorced __ Cohabitate __ Widowed __

Emergency contact _____ Relationship _____ Telephone _____

Information about your Spouse/Partner

Name: _____ Social Security # _____ - _____ - _____

Date of Birth: _____ - _____ - _____ Age: _____

Sex: Male _____ Female _____ MTF _____ FTM _____ Other _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address _____

Occupation: _____ Employer: _____

Marital Status: Single __ Married __ Divorced __ Cohabitate __ Widowed __

Other People Living in the Home (use the back of this form if you need more space)

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Insurance Information

Primary Insurance Company: _____ Auth.# _____
Insured's Name: _____ DOB: __ - __ - __
ID# _____ Group# _____
Secondary Insurance Company: _____ Auth.# _____
Insured's Name: _____ DOB: __ - __ - __
ID# _____ Group# _____

Medical Information

Doctor's name: _____ Phone # _____
Address: _____ City: _____ State: ____ Zip: _____

May I contact your doctor so that we can coordinate care? Yes No

Do you have any serious medical conditions? Yes No If yes, please describe:

Please list all medications (over-the-counter and prescription) and their dosages that you are currently taking:

Please list all allergies to medications or food:

Treatment Information

Why are you seeking counseling now? _____

Who referred you to us for counseling? _____

Have you ever experienced any of the following?

Alcohol/drug abuse Yes No Physical abuse Yes No

Suicide attempt Yes No Sexual abuse Yes No

If yes to any of the above, please briefly explain: _____

Have you been in counseling before? Yes No If yes:

With whom/when: _____

For what reason: _____

Have you been hospitalized for psychiatric reasons? Yes No If yes:

Where/when: _____

For what reason: _____

PATIENT'S OR AUTHORIZED PERON'S SIGNATURE: I authorize the release of any medical or other information necessary to process insurance claims (YES NO) and I authorize payment of medical benefits to Counseling Las Cruces for services rendered (YES NO).

SIGNED: _____ **DATE:** _____