INTAKE QUESTIONAIRE

Today's Date _____ Social Security Number _____

Name _____ Marital Status _____

Address _____ Date of Birth _____

_____ Age _____

Home Phone _____ Height _____

Work Phone _____ Weight _____
(Please Weigh In)

1) Briefly state what brought you here.

_____

_____

_____

_____

1) Who lives in your household? Please list names, ages and relationship.

_____ _____

_____ _____

_____ _____

_____ _____

1) Please list any medication you are currently taking.

_____

1) Who prescribed this medication?

_____

1) Who is your primary care physician?

Name _____

Address _____

Phone _____

Do you give permission for your doctor to be notified of your treatment? YES _____ NO _____

Please sign here if you give permission for your claim to be filed through this office. _____

I understand that my fee per hour is $ _____ for individual therapy and/or $ _____ for group therapy. I also understand and agree that I am responsible for my fee if, for whatever reasons my insurance company denies coverage. I also understand that I must give the *Life Mastery Center* twenty-four (24) hours notice of intent to cancel an appointment or I will be responsible for the fee for the scheduled hour.

Signature _____ Date _____

NEW CLIENT INFORMATION RECORD (PLEASE PRINT OR WRITE LEGIBLY)

CLIENT INFORMATION

PATIENT'S NAME (LAST, FIRST, MIDDLE)	SEX		MARITAL STATUS					DATE OF BIRTH	AGE	SOCIAL SECURITY NO.
	M	F	S	M	W	D	SEP			

STREET ADDRESS ☐ PERMANENT ☐ TEMPORARY	CITY AND STATE	ZIP CODE	HOME PHONE NO.
PATIENT'S EMPLOYER OCCUPATION (INDICATE IF STUDENT)	BUSINESS PHONE NO.		
EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP CODE	

HEIGHT	WEIGHT	IN CASE OF EMERGENCY – PLEASE NOTIFY

SPOUSE'S NAME		
SPOUSE'S EMPLOYER OCCUPATION (INDICATE IF STUDENT)		
EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP CODE
NEAREST RELATIVE	ADDRESS	HOME PHONE NO.

IF CLIENT IS A MINOR OR STUDENT

MOTHER'S NAME	STREET ADDRESS, CITY, STATE AND ZIP CODE	HOME PHONE NO.
MOTHER'S EMPLOYER	OCCUPATION	BUSINESS PHONE NO.
EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP CODE
FATHER'S NAME	STREET ADDRESS, CITY, STATE AND ZIP CODE	HOME PHONE NO.
FATHER'S EMPLOYER	OCCUPATION	BUSINESS PHONE NO.
EMPLOYER'S STREET ADDRESS	CITY AND STATE	ZIP CODE

INSURANCE INFORMATION (PLEASE PRESENT INSURANCE CARDS TO THERAPIST)

PERSON RESPONSIBLE FOR PAYMENT	SOCIAL SECURITY NO.	D.O.B.
☐ BLUE SHIELD (GIVE NAME OF POLICY HOLDER) OF MD	MEMBERSHIP NO.	GROUP NO. MAJOR MEDICAL
☐ MEDICARE PRIMARY INSURANCE? YES NO	☐ MEDICAL ASSISTANCE	EFFECTIVE DATES:
☐ OTHER (WRITE IN NAME OF INSURANCE COMPANY)	POLICY NO./SOCIAL SECURITY NO. OF POLICY HOLDER - EMPLOYEE: /	
OTHER INSURANCE COMPANY ADDRESS		
GROUP NO.:	POLICY HOLDER/EMPLOYEE NAME:	

MARYLAND ONLY

REFERRED BY

☐ PHYSICIAN _____ ☐ PATIENT _____ ☐ YELLOW PAGES

ADDRESS _____ ☐ OTHER _____

We request that office visits be paid at the time the service is rendered.

AUTHORIZATION: I hereby authorize my therapist to furnish information to insurance carriers concerning my diagnosis, and I hereby assign to the therapist all payments for services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.

_____ (Signature)