

**JOY SHIVAS MSW LCSW BCD**  
**Associates in Counseling and Personal Development**  
**INTAKE INFORMATION**

Name \_\_\_\_\_ Date of 1<sup>st</sup> Appointment \_\_\_\_\_  
Address \_\_\_\_\_ Date of Birth \_\_\_\_\_  
\_\_\_\_\_ Home Phone \_\_\_\_\_ Work \_\_\_\_\_  
\_\_\_\_\_ Cell \_\_\_\_\_ Pager \_\_\_\_\_  
Temp Address \_\_\_\_\_ Social Security # \_\_\_\_\_  
\_\_\_\_\_ Who referred you? \_\_\_\_\_  
Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_  
\_\_\_\_\_

**May I contact you at all of the numbers listed above? Yes \_\_\_ No \_\_\_ . If not, where may I contact you to change or make an appointment, etc.**

\_\_\_\_\_ ?  
Are you employed?  
Yes \_\_\_ No \_\_\_ Fulltime \_\_\_ Parttime \_\_\_ Occupation \_\_\_\_\_  
Employer name \_\_\_\_\_ Student: Part time \_\_\_\_\_ Full time \_\_\_\_\_  
Employer address \_\_\_\_\_ School \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_  
Primary Insured \_\_\_\_\_ Social Security # \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Relationship to Insured: self \_\_\_ spouse \_\_\_ child \_\_\_ other \_\_\_  
Address of Insured \_\_\_\_\_ Employer of Insured \_\_\_\_\_  
\_\_\_\_\_

Is there another health insurance? Yes \_\_\_ No \_\_\_ Name of other insurance \_\_\_\_\_  
ID# \_\_\_\_\_ Group # \_\_\_\_\_ Primary Insured \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_  
Relationship to insured: self \_\_\_ spouse \_\_\_ child \_\_\_ other \_\_\_  
Address of Insured \_\_\_\_\_ Employer of Insured \_\_\_\_\_  
\_\_\_\_\_

Is your condition related to current or previous employment? Yes \_\_\_ No \_\_\_  
Auto accident? Yes \_\_\_ No \_\_\_  
Other accident? Yes \_\_\_ No \_\_\_

If so, who is responsible for claims?  
\_\_\_\_\_

\_\_\_\_\_  
Prior and current mental health/substance abuse treatment (in and outpatient)  
\_\_\_\_\_

\_\_\_\_\_  
Name of primary care physician \_\_\_\_\_ Tele No \_\_\_\_\_  
Allergies \_\_\_\_\_  
Current medications and dosages \_\_\_\_\_  
\_\_\_\_\_

Meds used in the past \_\_\_\_\_

Emergency contact person & relationship to you \_\_\_\_\_

Telephone numbers \_\_\_\_\_

Client Signature (and Parent/Guardian Signature when appropriate)      Date

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