NEW LEAF INSTITUTE INTAKE INFORMATION

Name_____ Date_____

Address_____ Home telephone #_____
Cell telephone #_____
City/State/Zip _____ Work telephone #_____

Social Security #_____ Date of Birth_____

Employer_____ Date of Hire_____

Employer's Address_____

Marital Status: ___ Married; ___Separated; ___Divorced; ___Single; ___ other:_____

In Case of Emergency, whom should we contact:_____
How do we contact them?_____

Who is your primary physician?_____
Physician's Telephone #_____Physician's address_____
Are you currently taking any medications? YES/NO Please list:_____
_____
_____
Do you want your physician to be notified that you are seeking services? Yes / No

Who referred you? _____
May we inform them you followed through? Yes / No

Have you received counseling/psychotherapy services before? Yes / No
With whom:_____
Describe:_____

Do you plan to file insurance claims for eligible services? YES / NO (circle one)
If yes, please provide us with a copy of your insurance card and complete the following information. Also, please make sure to complete Page 9 of the Service Agreement.

Insurance Name:_____
Insured's Name:_____
Relationship to Insured: ___self ___spouse ___child ___other (check one)
Insured's Social Security # _____
Insured's Date of Birth:_____
Insured's Employer:_____
City/State/Zip Code:_____