New Outlook Counseling Center

INTAKE INFORMATION

CLIENT INFORMATION (Please Print) **Today's Date**_____

Client Last Name _____First Name_____MI____ Sex ___M ___F

Address _____City _____ State _____ Zip _____

Phone Number_____Work Phone_____A message may be left: yes or no

Date of Birth _____ Social Security Number _____ Marital Status _____

Employer/School_____ Occupation _____

Permanent Address_____

Spouse's Name **OR** if Client is a Minor Child Name of Parent or Guardian (Last, First, MI)

Last Name _____ First Name_____MI____ Sex ___M___F

Date of Birth _____ Social Security Number _____

Spouses' Employer/Minor Child's Parent's/Guardian's Employer _____

Occupation _____ Telephone_____

In Case of Medical or Mental Health Emergency: _____ Telephone Number _____

Relationship to Client _____

INSURANCE INFORMATION

Last Name _____First Name_____ MI___ Sex ___M___F

Address _____ City _____ State _____ Zip _____

Phone Number: _____ Work Phone_____ Date of Birth _____

Social Security Number _____Employer _____

Insurance Company_____Insurance I.D. Number _____

Insurance Group #_____

Insurance Address Telephone Number _____

Do you have a secondary insurance? _____ Please fill out secondary information on back.

MEDICAL INFORMATION

Primary Care Physician _____ Phone Number _____

Address _____City _____ State _____ Zip _____

Current Medical Issues/Allergies_____

Medications _____

SECONDARY INSURANCE INFORMATION

Last Name _____ First Name_____ MI___Sex ___M___F

Address _____City _____ State _____ Zip _____

Phone Number: _____ Work Phone_____ Date of Birth _____

Social Security Number _____ Employer _____

Insurance Company_____Insurance I.D. Number _____

Insurance Group #_____

Insurance Address Telephone Number _____