APOGEE
Human Services Consultants, LLC
Reach Beyond Limits.

Client Intake Form

Name: ____ DOB: _________________________
Sex: M F Other Marital Status: Sin / Mar / Div / Sep / Wid / Other
Address:____
E-mail: ____
Cell Phone: ___________________________ Work Phone: ___________________________________
Home Phone: _____________________________
What is your preferred mode of contact to discuss scheduling and coordinate potential services?
_______________________________________ Other_______________________________________

Are you under 18 years old? YES NO (If yes, Identify parent/Legal guardian as ER contact)

Emergency Contacts

Name:____________________________________ Phone:______________________________
Name:____________________________________ Phone:______________________________
Name:____________________________________ Phone:______________________________

Primary care physician ______________________________ Practice_______________________
Address: ____
Telephone #: (_____) ____________________ Fax #: (______) _______________________________

Psychiatrist/Psychologist ______________________________ Practice_______________________
Address: ____
Telephone #: (_____) ____________________ Fax #: (______) _______________________________

Other Provider________________________________ Practice________________________________
Address: ____
Telephone #: (_____) ____________________ Fax #: (______) _______________________________

Current medications and dosage

____ ____
____ ____
____ ____
____ ____

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Payment Information

Do you plan on using your health insurance to pay for our services? YES NO

If so, what type of health insurance do you have? ____

Subscriber's Name: ______________________________ Subscriber's Date of Birth: _____________

Subscriber's Social Security Number _________________________________

Insurance Identification Number: ________________________ Suffix # __________

Insurance telephone # for mental health benefits: (_____) _________________________________

Insurance telephone # for medical benefits: (____________________________________

When does your health plan renew: ________________________

Employer or other entity where health plan is obtained

____

Is the health plan a union or employer self-funded or trust plan? YES NO

If so, provide employer or plan contact name and telephone if available:

Name: _____________________________________ Phone #: _______________________________

Do you have secondary insurance? YES NO

If yes, please complete:

What type of secondary health insurance do you have?______________________________________

Subscriber's Name: ___________________________________ Subscriber's Date of Birth: __________

Subscriber's Social Security Number _________________________

Insurance Identification Number: __________________________________ Suffix # _____________

Insurance telephone # for mental health benefits: (_____) _________________________________

When does your secondary health plan renew: _________________ Unsure

Employer or other entity where health plan is obtained ____________________________________ Is the health plan a union or employer self-funded or trust plan? YES NO Unsure

If so, provide employer or plan contact name and telephone if available:

Name: ____ Phone #: (______) ___________________

Has the patient used any mental health insurance benefits this calendar year? YES NO

If so, what is the number of behavioral health visits used this year?__________

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Treatment History

Has the potential patient ever been hospitalized for psychiatric reasons? YES NO

If yes, when was the last hospitalization: ____

Facility____ Length of stay_____________

Has the potential patient ever been hospitalized for substance abuse? YES NO

If yes, when was the last hospitalization: ____

Facility____ Length of stay______________

Nature of treatment received ____

Are the services you are seeking related to an automobile accident? YES NO

If related to an automobile accident please provide:

Insurance Carrier: _____________________________ Policy Number: _________________

Address: ____

Insurance Adjuster Name (full name): ____

Phone #: ________________________ Claim #: ______________________________________

Are the services you are seeking related to a workplace accident? YES NO

If related to a workplace accident, we do not accept workers compensation and services related to workplace injuries are NOT covered by your health insurance plan.

Please check here if you accept and are willing to pay our fees at time of service. ☐ **I agree**

Please see the fee agreement.

Are the services you are seeking related to any type of lawsuit, hearing or other legal process?

YES NO

If yes, please explain: ____

Who, if anybody, referred you to our practice?

____

Do we have permission to thank the person who referred you? YES NO

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List all past and current medical diagnoses/problems of the potential patient:

____

____

____

____

List the names and professions of any other professionals you have consulted about these problems (within the past 3 years):

Name	Profession	Contact
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

What type of services are you seeking? Please check all that apply.

( ) Medication/Psychopharmacology
( ) Family Therapy
( ) Neuropsychological Evaluation
( ) Consultation
( ) Educational Therapy/Tutoring
( ) Independent Living Services
( ) Family Support Services
( ) Individual Psychotherapy
( ) Group Therapy, which group?
( ) Psychological Evaluation
( ) Developmental Evaluation
( ) Family Stabilization Services
( ) Case Management Services
( ) Other, please specify: ______________________

Briefly describe the nature of the problem you are seeking services for:

____

____

Is the patient involved with a state agency? Please check all that apply

☐ DCF ☐ DTA ☐ DDS ☐ DMH ☐ DYS ☐ MRC ☐ ORI

☐ Veterans Services ☐ Elder Affairs ☐ Other______________________

Please identify any disabilities or factors that may interfere with your treatment?

____

____

____

____

Other information relevant to the services you are seeking:

____

____

____

____

Name_________________________________ Date_________________________

Signature____