

The Institute for Essential Change (IEC)
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NEW PATIENT INTAKE FORM

| | | | | | |
|--|-----|---------------------------------|-----------------------------|-----------------------------|-------|
| Client Name (Last,Middle,First) | | Race | Sex | Marital Status | Email |
| Address (Street,City,State,Zip) | | | Home Phone Number | | |
| Permanent Address (Street,City,State,Zip) | | | Social Security Number | | |
| D.O.B. | Age | Birthplace | | Previous Patient: Y or N | |
| Referred By (Name & Address) | | Referral Phone Number | | Therapist Assigned | |
| Client Occupation | | Employer Name | | Employer Number | |
| Insurance or Self-Pay (circle one) Yes No | | Insurance Policy # | | | |
| Insurance Carrier | | Address (Street,City,State,Zip) | | Phone Number | |
| Insurance Group # | | Insurance ID# | | Insured Place of Employment | |
| Briefly Describe Reasons for Needing Counseling Trx: | | | | | |
| Any Medical Conditions or Prescribed Medications: | | | | | |
| Have you ever sought help/treatment before? Y or N | | | If Yes, what kind and when? | | |

Patient Signature: _____

Admitting Staff Signature: _____

In Case of Emergency, Contact: _____ **Phone:** _____