

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)					
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?		

Admitting Staff Signature: _____