



We Belong Counseling, Corp.

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INTAKE CONSENT FORM

NAME: _____ MALE/FEMALE: _____ DATE: _____

REFERRAL SOURCE: _____

DATE OF BIRTH/PLACE: _____ AGE: _____

SOCIAL SECURITY #: _____ DRIVER'S LICENSE #: _____

STATUS: Single () Married () Separated () Divorced () Widow/er () Other ()

IF CHILD/ADOLESCENT, PARENT/GUARDIAN'S NAME(S): _____

ADDRESS: _____ CITY: _____ ZIP: _____

PRIMARY LANGUAGE: _____ SECONDARY LANGUAGE: _____

FOR ROUTINE MESSAGES: Phone # _____ () Cell () Home () Work

Alternative Phone # _____ () Cell () Home () Work

FOR CONFIDENTIAL MESSAGES: Phone # _____ () Cell () Home () Work

Alternative Phone # _____ () Cell () Home () Work

PERSON & PHONE # TO CALL IN EMERGENCY: _____

I consent and authorize my mental health practitioner and/or their staff to communicate with the contact person above regarding all confidential matters in a situation deemed as an emergency.

Patient/Guardian's Signature: _____ Date: _____

E-MAIL: _____

Do you e-mail regularly? () Yes () No Okay to e-mail appointment/billing info? () Yes () No

Okay to e-mail confidential info? () Yes () No Okay to e-mail newsletters? () Yes () No HIGHEST

GRADE/DEGREE: _____ TYPE OF DEGREE: _____

EMPLOYER: _____ OCCUPATION: _____

PURPOSE OF VISIT: _____

HISTORY OF PRESENTING PROBLEM: _____

ESTIMATE THE SEVERITY OF THE ABOVE PROBLEM: () Mild () Moderate () Severe

LEGAL HISTORY: () Current () Past _____

CURRENT MEDICATIONS & DOSAGES: _____

IF PATIENT IS A CHILD:

Name of school _____ Grade _____ Teacher(s) _____

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