Dr. Sharlene Bird

CLIENT INTAKE FORM

Name: ____ Date: __________________

DOB: ____/______/______ Age: _____ Social Sec. # ______________________

Insurance carrier (if applicable): ________________________________

ID #: ____________________ Group #: ______________________ Policy #:____________________

Name of Insured:________________________DOB:_____________Employer:_________________

Insured ID #: _________________________ Relationship to you: ____________________________

Home Address:____

City/State:____________________________ ZIP: _______________

Home #: ____________________ Cell #: ____________________ Work #: ____________________
May I leave a message at your home#? Yes No Work #? Yes No Cell #? Yes No

Email address: ___________________________________

Employer: __________________________________ Profession/Occupation___________________

Marital Status:(Circle One) Single Married Partnered Separated Divorced Widowed (Yrs______)

Spouse/Partner/Significant Other Name: ____

Work #: ______________________ Cell #: ______________________

Emergency contact Name: _________________________ Relationship: _______________________

Address: __________________________________ City/State: ________________ ZIP: __________

Phone #: ____________________

Office Use:		
Tx Modality: ______________________	Fee: ________________	DX: ____________________

Current Medications: Please list with dosage. ____

____

Previous Counseling/Therapy? Yes No If Yes, when & duration? ____________________

Where and with whom? ____

Does anyone in your family have any history of mental illness (such as depression, anxiety, substance abuse, etc.)? If so, please list ____

____

	Poor				Excellent
How do you sleep at night?	1	2	3	4	5
How is your nutrition?	1	2	3	4	5
Do you drink alcohol?	Yes	No	How much? ___________________________		
Do you drink coffee?	Yes	No	How much? ___________________________		
Do you smoke cigarettes?	Yes	No	How much? ___________________________		

Do you smoke pot or use other recreational drugs? Yes No Frequency________________

Does any of the following items apply to your concern today?

_____Anger/temper

_____Anxiety

_____Depression

_____Family or business consultation

_____Fearfulness

_____Lifestage issues

_____Marital issues

_____Multicultural issues

_____Problems with social relationships

_____Sexual Abuse/Trauma

_____Sexual Concerns/Dysfunction

_____Thoughts of hurting yourself or others

_____Trouble making decisions

_____Other (Specify)___________________

Brief summary of reason for seeking treatment: ____

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Whom were you referred by? ____

I understand that Dr. Bird has chosen to work without insurance assignment or third party payment. Reimbursement for services is strictly between myself and my insurance carrier. I understand that insurance coverage is not guaranteed and I am responsible for full payment of services rendered.

Signature____Date____________________