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**INTAKE FORM**

Client Name: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Occupation \_\_\_\_\_ Place of Employment/School and Phone Number: \_\_\_\_\_

Marital Status: Single: \_\_\_ Married: \_\_\_ Separated: \_\_\_ Divorced: \_\_\_ Widowed: \_\_\_

Spouse/Significant Other's Name: \_\_\_\_\_  
(Parent's Name if Client is a Minor)  
Place of Employment/Phone Number: \_\_\_\_\_

Please list names and ages of children (siblings if client is a minor): \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:**

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Telephone: \_\_\_\_\_

Name of Person Who Referred You: \_\_\_\_\_

**Treatment History:**

Primary Care Physician Name and Number: \_\_\_\_\_

Are you currently taking any medications? \_\_\_ If yes, please list name and dosage information:

Have you ever been in therapy before? \_\_\_ If yes, please list dates and reason for treatment:

**Insurance Information:**

Insured's I.D. Number \_\_\_\_\_  
Insured's Name (Last Name, First Name, Middle Initial) \_\_\_\_\_  
Insured's Address \_\_\_\_\_  
Insured's Policy Group or FECA Number \_\_\_\_\_  
Insured's Date of Birth \_\_\_\_\_  
Employer's Name or School Name: \_\_\_\_\_  
Is There another Health Benefit Plan? \_\_\_\_\_  
I give permission for Laura Aube, MS, LPC, ATR-BC to bill the above insurance for services she provides me.  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_