MAPLE SHADE INTAKE FORM

Section I

Client Name: ____________________ Date: __________

Address: ____________________

____

Telephone: (Home)__________(Work)__________ Marital Status:__________

Date of birth: __________ SS#:__________ Race:______ Sex:______

School ____________________

Primary Care Provider:____________________

Address: ____________________

Telephone: ____________________

Child's: Custodian:____________________

Address: ____________________

Telephone: (Home)__________(Work)__________ Marital Status:__________

Date of birth: __________ SS#:__________ Race:______ Sex:______

Guardian Email: ____________________

If a child: 3. Guardian if different from custodian:____________________

Address: ____________________

Telephone: (Home)__________(Work)__________ Marital Status:__________

Date of birth: __________ SS#:__________ Race:______ Sex:______

Email address: ____________________

Referred by: __________ Agency: __________ Phone Number :__________

Reason for referral: ____________________

____

Presenting problems: ____________________

____

____

Strengths: ____________________

History of Problems: ____

____

Legal Issues ____

Previous therapy: ____

Prior psychiatric Hospitalizations: ____

Substance abuse History/treatment: ____

Allergies: ____

Current Meds: ____

Section II

Insurance Provider:______________________ Individual recipient #:______________________

EVS- Eligible Not Eligible Grey Zone Other Insurance

Value Options: Requested initial 2 Open OMS (guardian contacted to change providers? value opts: 800 888 1965)

2 Emergency Contacts phone #

1.______________________ Phone Number ______________ Relationship__________

2.______________________ Phone Number ______________ Relationship__________

Pharmacy: ______________________________

Pharmacy Address:______________________________

Pharmacy Phone Number: ______________________

Siblings:

______________________ **Relationship**______________ **DOB** ______________

______________________ **Relationship**______________ **DOB** ______________

______________________ **Relationship**______________ **DOB** ______________

______________________ **Relationship**______________ **DOB** ______________

____________________________________ **Relationship**_____________________ **DOB** ______________________
____________________________________ **Relationship**_____________________ **DOB** ______________________

Information given by: _________________________________ Relationship to client:___________________________

Intake Data taken by: _________________________________

CLINICAL DIRECTOR TO COMPLETE

Accepted into Program: YES NO
Priority: HIGH MODERATE LOW

Therapist assigned for intake: _________________________________

Therapist assigned for caseload: ________________________________

Intake Scheduled for: ____

Doctor Visit scheduled for: ____________________________________

Clinical Director Signature:____________________________________ **Date**_____________