Gallatin Psychotherapy, Inc.

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Client Intake Form

Client Information	
Name	
Street	
City, ST, ZIP	
Today's Date:	OK to leave msg?
Ph (day)	Y N
Ph (eve)	Y N
Ph (cell)	Y N
DOB	Age
Social Sec #:	
Emergency Contact	

Requested Services **(Check all that apply)**
✓ Initial Consultation
❑ Adjust to Life Change
❑ Anxiety, Depression, Stress or Anger
❑ Trauma Recovery
❑ Couple or Family Counseling
❑ Build Self-Esteem & Effectiveness
❑ Executive Performance Enhancement
❑ Other _____

Physician
Primary
Psychiatrist (if any)

Billing Information
Responsible party (if other than client)
Street
City, ST, ZIP
Ph (day)
Ph (eve)

Insurance Information (BCBS, Medicaid only)
Subscriber
Subscriber ID
Subscriber DOB
Employer
Group
Subscriber SS#
Relation to insured

Referral
How did you hear of us?
If from a person, OK to thank? Y N

I understand I must also read and sign the Psychotherapy Services Agreement and Fee Agreement before services can be given. I understand I am responsible for payment at the time services are rendered.

_____ _____

Client Name (Print) Responsible Party (Print)

_____ _____

Signature & Date Signature and Date