

Rosario Counseling & Associates

New Patient Initial Intake
809 Spring Forest Road, Suite 1000
Raleigh, NC 27609

Date _____

Client Information

Name: _____ DOB: _____ Age: _____ Email: _____

Address: _____

Referred by: _____ Reason they referred you: _____

Home Phone: _____ Cell: _____ Work Phone: _____

I authorize representatives of Rosario Counseling & Associates to leave messages or send mail to my:

- Address Email Home Phone with my family members Cell Phone Work Phone

Emergency Contact: _____ Phone Number: _____

Payment for Services

Please select the appropriate method: Insurance Self-pay/Out-of-Pocket

*If using Insurance please complete the section below:
Filing Insurance claims is a service provided by is this office.*

Name of Insurance Co: _____ Phone: _____ - _____ - _____

Address: _____

Policy ID #: _____ Group #: _____

Primary Policy Holder

Name: _____ DOB: _____ Phone _____

Address: _____

SS#: _____ - _____ - _____ Relationship: _____ Employers Name: _____

Please present your insurance Card if applicable and Drivers license (as proof of identity) to the Administrative Assistant so copies can be made for your business file.

Payment for Services

I understand that I am responsible for payment of services at the time services are rendered.

Notice to insurance clients: Make sure that you understand your policy requirements and benefits for mental health services. Most insurance companies have a disclaimer that authorization does not guarantee payment of services. In addition, you might have a deductible to satisfy before your insurance covers any charges.

Signature: _____ Date: _____

For business office use only:

- Disclosure Statement
- Initial Intake – page 1 & 2
- Privacy Policy
- Symptom checklist
- Copied page 1 of intake for Clinical file
- Drivers License picture on file
- Insurance card on file

Staff Initials _____

Rosario Counseling & Associates

New Patient Initial Clinical Intake

Name: _____

Date: _____

Education & Vocation InformationDegrees Completed: High School Diploma GED Associates Bachelors Masters Doctorate

Occupation: _____ Employer: _____ How long? _____

Relationship Information

Marital Status: _____ Number of Marriages: _____ Number of Divorces/Annulments _____

Name: _____ Date of Marriage: _____ Date Marriage Ended: _____

Name: _____ Date of Marriage: _____ Date Marriage Ended: _____

If widowed, your age at the death of spouse: _____ Number of years married: _____

Children: Yes ___ No ___ Name: _____ DOB: _____ Age: _____

If client is a minor list Siblings Name: _____ DOB: _____ Age: _____

Name: _____ DOB: _____ Age: _____

Name: _____ DOB: _____ Age: _____

Name: _____ DOB: _____ Age: _____

Medical Information

Primary Care Doctor: _____ Name of office _____ Phone: _____

Date of last medical exam: _____ Findings _____

Rate your general health: Very good ___ Good ___ Average ___ Fair ___ Poor ___

Name of Specialists _____ Name of office _____ Phone: _____

Do you have any diagnosed health problems? _____

Current Prescription Medications & Doses: _____

Mental Health Information

Have you seen a Psychiatrist or Counselor in the past? _____ If yes, was it helpful or effective? _____

What were the reasons for the visit: _____

Are you currently receiving mental health services? _____ If yes, name the provider and type of services you are receiving: _____

Why do you seek counseling today? _____

How long has this problem existed? _____

What caused you to seek my services at this time? _____

What outcome are you seeking? _____