

Intake Form for Sara Jambon, M.Ed, LPC, LMFT

Client Identifying Information:

Patient's Name: _____ Soc. Sec. #: _____

Address:

Phone: _____ Cell Phone: _____

e-mail: _____ Cell Phone Carrier: _____

Please provide a password for access to online appointment setting: _____

Today's Date ____/____/____, DOB: ____/____/____, Current Age: ____ Sex: M ____ F ____

Race (optional): African American. ____ Asian American ____ Caucasian ____

Hispanic/Latino ____ Native American : ____ Other: _____

Relationship Status: Single ____ Married ____ Divorced ____ Living w/Significant Other ____

Health Insurance Information: (Policy number, Group Number, Phone Number, Co-Pay Amount)

ID # _____ Group # _____

Primary Insurance Company: _____

Primary Carrier of insurance: _____ DOB: _____

Employer of Primary Insurance Carrier: _____

Insurance Phone (Customer Service/ Behavioral health number on the back of the card)

Insurance Company Address (on back of card): _____

Source of Referral

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Current Presenting Problem(s). Onset and Acuity:

___ depression ___ anxiety: ___ family issues ___ disordered eating/body image ___ substance use

Other/Details: _____

___ mood instability ___ adj. to college life ___ academic problems ___ grief/bereavement ___ ADHD
___ relationship issues ___ sexual assault ___ other trauma
___ psychoses/delusions

Current Prescriptions Medication and Psychiatric History:

Current/previous Anti-Depressant/ Anxiety / ADHD/ Psychiatric medication prescriptions:

Previous Counseling (Clinician, Location, Reason):

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Previous psychiatric hospitalizations (Location, Reason):

Family psychiatric history:

Previous Suicide Attempts Y____ N____ History of Cutting Y____ N____

Current Support System: (Family, Friends that you can depend on):

Relevant Medical Conditions (heart issues, thyroid, diabetes,etc.) :

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Any Known Drug Allergies: No ____ Yes ____: _____

Primary Care Physician: _____

Primary Care Address:

Primary Care Phone Number: _____

Do you want the therapist to contact your PCP regarding therapy progress? Y____N____

(This would be for coordination of care and medication management purposes.)

By signing below you authorize Sara Jambon, M.Ed, LPC, LMFT to contact, bill, or otherwise disclose your information in order to collect payment. In the event that your insurer does not cover all charges, you accept responsibility for payment.

Signature: _____

Printed Name: _____

Date: _____