
# INTAKE FORM

PLEASE FILL OUT ALL FORMS (1 OF 5)

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LINDAKORNETTLCSW.COM

NAME | DATE OF BIRTH | SOCIAL SECURITY NUMBER

HOME ADDRESS | CITY | STATE | ZIP

WORK ADDRESS | CITY | STATE | ZIP

HOME PHONE
OK TO CALL: ☐ YES ☐ NO
OK TO LEAVE MESSAGE: ☐ YES ☐ NO

WORK PHONE
OK TO CALL: ☐ YES ☐ NO
OK TO LEAVE MESSAGE: ☐ YES ☐ NO

CELL PHONE
OK TO CALL: ☐ YES ☐ NO
OK TO LEAVE MESSAGE: ☐ YES ☐ NO

EMAIL

EMERGENCY CONTACT | EMERGENCY CONTACT PHONE

REFERRED BY | TELEPHONE

LIMITED RELEASE: ☐ APPROVED ☐ DISAPPROVED

PHYSICIAN | TELEPHONE

LIMITED RELEASE: ☐ APPROVED ☐ DISAPPROVED

HEALTH INSURANCE COMPANY | MEMBER ID | GROUP NUMBER

RELATIONSHIP TO HEALTH INSURER | TELEPHONE

ADDRESS | CITY | STATE | ZIP

MEDICAL CONDITIONS

PRESENT MEDICATIONS

REASON FOR SEEKING SERVICES

WHAT HAVE YOU ATTEMPTED TO ADDRESS ON YOUR OWN?

HAVE YOU CONSULTED WITH OTHER PROFESSIONALS REGARDING THIS MATTER? IF SO, WHOM? DO YOU KNOW OF ANY POSSIBLE MEDICAL OR GENETIC (FAMILY) CAUSES OF THIS PROBLEM?

ARE THERE ANY SPECIAL FAMILY, WORK, LEGAL OR OTHER STRESSORS OF WHICH I SHOULD BE AWARE?

**CONSENT TO TREATMENT**

I consent to psychotherapeutic evaluation and treatment. i have received a client contract and agree with the terms stated therein.

CLIENT SIGNATURE | DATE