STEPHANIE MCLEOD-ESTEVEZ, LCPC
222 Saint John St, Suite 219, Portland, ME 04102 (207) 370-5520

INTAKE FORM

Today's Date:________ **Dx:__________________**

Client's Name__________________________________ **DOB___/___/_____**

Address______________________________________ City____________ State____ Zip_______
Mailing Address ____
Home Phone_____________ Work Phone____________ Cell Phone______________
Referred by___________________________________
Gender ___________ Highest grade/degree_____ Currently employed? Y or N

Occupation/position___________________________________ Relationship status: ____________________

If Client is a Minor:

Name of Parent or Guardian:________________________ Home Phone_______________
Work Phone _______________
School___________________________Grade______Teacher____________________

Person to call in emergency:____________________________ Phone______________

Person to call in emergency:____________________________ Phone______________

Concerns that brought you to therapy: ____

Current Medical Problems____

Current Medications ____
Primary Care Physician____
Previous Therapists____
Have you ever been hospitalized for psychiatric reasons? Y or N
If yes, when and where?____
____

Insurance Company____________________________ Certificate #_______________

Group #________________ Name of Subscriber of the Policy__________________
Subscriber's DOB: ____________
Who is financially responsible for this bill? __________________________________

By signing below you authorize Stephanie McLeod-Estevez, LCPC to disclose to your insurance company or other authorized-benefits provider all information that is customary and necessary to process your benefits claim. It is understood that this does not guarantee in any way the payment of such a claim. If your benefits provider does not pay for the services provided than you are responsible for any outstanding balances owed.

I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS.

Client Signature: ____________________________________ Date: ___________________

(Parent if Minor)