

STEPHANIE MCLEOD-ESTEVEZ, LCPC
56 William St, Portland, ME 04103 (207) 370-5520

INTAKE FORM

Today's Date: _____ Dx: _____

Client's Name _____ DOB ___/___/___ Gender _____

Address _____ City _____ State _____ Zip _____

Mailing Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Referred by _____ Highest grade/degree: _____

Employed? Yes or No 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: _____ Subscriber address (if different): _____

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)