Intake Form

Contact Information:

Name: ____ DOB: ___________________________

Address: ____

City: _________________________State/Zip: ____

Phone Number: ___________________________ May I leave a message: ☐ Yes ☐ No

Email: ___________________________________ May I email you: ☐ Yes ☐ No

Who referred you to According to Sykes? _______________________________________

Insurance Information – If using your insurance.

Name: ____DOB: ________

Address: ____

City: ________________State/Zip:_____________Phone Number: __________________

Name of Insurance Provider: ____

Insurance ID #: ____________________________ Group Plan #: __________________

Employer Name: ____

Client Information:

1. What do you hope to gain from services at this time?

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2. Have you ever received services with a family therapist, social worker, counselor, psychologist or psychiatrist? If so, when and how long?

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3. Have you ever been diagnosed with a condition or take any prescription medication that this therapist should be aware of?

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