Ince Counseling
Individual . Family . Couple . Corporate

Partnering with strong people through life's challenges

NEW CLIENT INFORMATION

Name: ____

Date of Birth: __________________ Age: __________

Occupation: _____________________________

Address: _____________________________________

____

Home Phone: __________________________________

Work Phone: __________________________________

Cell Phone: __________________________________

E-mail: ______________________________________

Emergency Contact Name: ____________________

Relationship to Emergency Contact: ____________

Current Partner/Spouse's name: ________________

Today's Date: _________________________________

Gender: ____ Sexual Orientation: __________________

Race/Ethnicity: _________________________________

Religion: _______________________________________

Referred by: ____________________________________

May I acknowledge referral: ☐ Yes ☐ No

Okay to leave messages? ☐ Yes ☐ No

Okay to leave messages? ☐ Yes ☐ No

Okay to leave messages? ☐ Yes ☐ No

Okay to e-mail you? ☐ Yes ☐ No

Phone Number: _______________________________

Marital Status: _________ Years in Relationship: _____

Age: ____ Occupation: __________________________

Current Physician: ______________________________ Phone: _________________ Last exam: ________________

Current Medications | Dose | Purpose

____

____

____

____

Are you currently receiving psychiatric or mental health services elsewhere? ☐ Yes ☐ No

Would you be interested in group sessions, mediation, coaching, etc? ☐ Yes ☐ No

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Current & Previous Mental Health Providers:

Provider Name | Dates of treatment | Contact Information

____

____

____

____

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Occupational Information

Are you currently employed? ☐ Yes ☐ No

If Yes, Who is your employer? ____

What is your position? ____

If No, are you a student? ☐ Yes ☐ No

If yes, what is the name of your school? ________________________________

Are you a part-time or full-time student? ☐ FT ☐ PT

Insurance Information

Insurance Provider: ____

ID Number: ____

Group Number: ____

Customer Service Telephone Number : ____

Insurance authorization to release information and assignment of benefits: I hereby Authorize Ince Counseling and Consulting LLC, and Tamara Ince to:

1. furnish my insurance company with any information requested concerning my present claim/s.
2. bill my insurance company and to accept payment due from that company on my behalf.

X____

signature **date**

Responsible party: is the person who will be paying the per-session fee for services.

Responsible Party Name: ____

Address: ____

Relationship to Patient: ____

DOB: ________________________ E-mail: ________________________

Home phone number: ________________________ Work phone number: ________________________

Mobile phone: ________________________

Thank you for taking the time to fill this form out!