



Ravenhill  
Psychological Services

## Client Intake Form

Client Name:		D.O.B.:	Age:
SSI #:	Marital Status:	Client ID #:	Gender:
Referral Source/County:		Contact:	
Reason for the Referral:			
Current Residence: <input type="checkbox"/> Family Residence <input type="checkbox"/> Out-of-Home Placement <input type="checkbox"/> Other			
Current Address: _____ (Street) (City) (State) (Zip)			
Duration at Current Address:			
Primary Contact #:		Therapist may leave a message:	
Type:		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Secondary Contact#:		Therapist may leave a message:	
Type:		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Family Information</b>			
Home Address: (if different from above)  (Street) (City) (State) (Zip)			
Parent/Guardian (if under 18 years of age):		Parent/Guardian (if under 18 years of age)	
Contact #:		Contact #:	
<b>Individuals Residing at this Residence</b>			
Name:		Age:	Relationship:
Name:		Age:	Relationship:
Name:		Age:	Relationship:
Name:		Age:	Relationship:
<b>Insurance Information</b>			
Primary Insurance:		Policy #:	Ins. Co. Telephone #:
		Group ID:	
Policyholder:		Relationship to Client:	
Secondary Insurance:		Policy #:	Ins. Co. Telephone #:
		Group ID:	
Policyholder:		Relationship to Client:	
Primary Care Physician:		PCP Contact #:	

