

**KAY ATCHISON, LCSW, ACSW**

2301 Stonehenge Drive, Suite 202

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**INTAKE INFORMATION**

Date: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Client 1: \_\_\_\_\_ Client 2: \_\_\_\_\_

Cell Phone1: \_\_\_\_\_ Cell Phone2: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt.# \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Age 1: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age 2: \_\_\_\_\_ Birth date: \_\_\_\_\_

Single \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Significant Other \_\_\_\_\_

Social Security #: \_\_\_\_\_ Employed by: \_\_\_\_\_

Occupation \_\_\_\_\_ Business Phone: \_\_\_\_\_

Business Address: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_ Relationship: \_\_\_\_\_

Insured Member Name: \_\_\_\_\_ Social Security#: \_\_\_\_\_

Insured Date of Birth: \_\_\_\_\_ Insured phone: \_\_\_\_\_ Business phone: \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Who may I thank for referring you? \_\_\_\_\_

**MEDICAL INFORMATION**

Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Notification to your primary physician may be made regarding your care.

Please circle medical concerns that apply to the patient:

Heart Problems	Cancer	Ulcer
High Blood Pressure	Arthritis	Epilepsy
Low Blood Pressure	Immunosuppressive Disorder	Headaches
Thyroid	Mental Health Care	Recent Weight Loss/Gain
Diabetes	Alcohol/Substance Abuse	Hepatitis

Additional medical information: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Prescribing Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_