Soaring Spirits Counseling LLC Client Intake and Assessment Form

Name: _____**Date:**_____/_____/_____

Phone Number(s): ( ) _____( )_____DOB: _____

Referral Source: _____

Self-Pay: ___No ___Yes
Insurance Provider: _____
_____
Name of insured: __Self __Other: Name: _____
Relationship: _____
_____
Private Insurance: Effective dates: _____ to_____
Policy/ID number/Group Number: _____
Contact name & phone number: _____
_____
Authorization Number: _____
Referral Number: _____
Effective dates for authorization/referral: _____
Authorization/Referral documentation information obtained: __No __Yes
Please bring your insurance card with you to your intake.

Presenting Issue(s) (Describe the problem specifically)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Goals(s) for treatment: _____
_____
_____
_____
_____
_____
_____