

Pathways Counseling

Intake Form

Today's Date _____ Appointment Date & Time _____

Patient Name: _____ DOB: _____

Parent/Guardian Name: _____

Address: _____

Phone: _____ Alternative Phone: _____

What would you like to address during therapy for yourself, child, or family? _____

Primary Care Physician/Clinic: _____

How did you hear about Pathways Counseling? _____

Health Insurance (Primary): _____

Individual ID: _____

Group ID: _____

Health Insurance (Secondary): _____

Individual ID: _____

Group ID: _____