Lia Roy, LMFT

Client Intake Information

Please complete all items on this form. In practice I have found that each item has importance and will be useful to help provide the best quality of service to you. Please Print or write legibly. Thank you.

Last Name			Date of Birth
Middle Name			SS #
First Name			Mental Health Insurance *(Yes)* *(No)*
Address			Company Name
Street			Contact Phone
City		Zip	Address
Home Phone ( )			Group#
Cell Phone ( )			Member #
May I leave a message (***Home***) or (***Cell***)			E.A.P. Authorization #, if applicable
May I email you? *(Yes)* *(No)*			
Email			

Marital Status: *(Married), (Never Married), (Widowed), (Separated), (Divorced), (Civil Union)*

Living Situation: *(Alone), (Spouse/ Partner), (Children), (Parent(s)), (Roommate(s)), Other*

Children living at home:			**Primary Insured or Responsible party:**	
Name	Age	Gender	Last Name	
		(M) (F)	First Name	
		(M) (F)	Middle Name	
		(M) (F)	Date of Birth	SS#
		(M) (F)	Contact Phone ( )	
Emergency Contact Name				
Relationship			Contact Phone ( )	
Employer Name			School Name	
Contact Phone ( )			Contact Phone ( )	
Address			City	
Street			Major of Study	
City		Zip	Last Education Completed:	
Occupation			(HS), (Some College), (4 yr), (Grad), (Post Grad)	

Whom may I thank for referring you? Name Phone ( )

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

(Yes) (No) If yes, Previous Practitioner Name

Contact Phone ( )