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CLIENT INTAKE FORM

DATE: _____

NAME: _____ DATE OF BIRTH _____ AGE: _____

PLACE OF BIRTH _____ SOCIAL SECURITY # _____

ADDRESS: _____

EMAIL ADDRESS: _____

HOME PHONE: _____	WORK PHONE: _____	CELL PHONE : _____
OK TO CALL <input type="checkbox"/> Yes <input type="checkbox"/> No	OK TO CALL <input type="checkbox"/> Yes <input type="checkbox"/> No	OK TO CALL <input type="checkbox"/> Yes <input type="checkbox"/> No
OK to leave a message <input type="checkbox"/> Yes <input type="checkbox"/> No	OK to leave a message <input type="checkbox"/> Yes <input type="checkbox"/> No	OK to leave a message <input type="checkbox"/> Yes <input type="checkbox"/> No

HIGHEST LEVEL OF EDUCATION ACHIEVED: _____ CURRENTLY IN SCHOOL Yes No

EMPLOYER: _____

WHOM MAY I THANK FOR REFERRING YOU: _____

YOUR REASON FOR SEEKING COUNSELING: _____

INSURANCE INFORMATION

INSURANCE: _____ INSURANCE TELEPHONE#: _____

INSURANCE PLAN#: _____ INSURANCE GROUP#: _____

SIGNIFICANT OTHER/FAMILY INFORMATION

SIGNIFICANT OTHER'S NAME: _____ DATE OF BIRTH _____ AGE: _____

NAME(S) AND AGE(S) OF CHILDREN: _____ AGE _____ AGE _____

_____ AGE _____ AGE _____

MOTHER'S NAME: _____ AGE _____ OCCUPATION: _____

FATHER'S NAME: _____ AGE _____ OCCUPATION: _____

EMERGENCY CONTACT: _____ PHONE #: _____