Family Service of El Paso
CLIENT INTAKE FORM

Date of Intake: _____

Client Name: _____ DOB: _____ Phone # : _____

Address: _____ Zip Code: _____ Email: _____

Partner/Guardian Name: _____ DOB: _____ SS#: _____

Children: Name: _____ Age: ____ DOB: _____ SS#: _____

Name: _____ Age: ____ DOB: _____ SS#: _____

Name: _____ Age: ____ DOB: _____ SS#: _____

Gross Family Income: $ _____ **Preferred Time: _____ A.M. _____ P.M.**
Preferred Language: _____ Second Choice: _____ (check box ☐ if 2nd choice is okay if preferred is unavailable)

☐ **EAP**
☐ **Medicaid***
☐ **Medicare***
☐ **Chips***
☐ **Insurance***

Name of EAP: _____ Auth. # (if applicable): _____

Name of Plan*

☐ **Traditional** ☐ **Superior** ☐ **El Paso 1st** ☐ **Molina** ☐ **Amerigroup**

☐ **Other**_____

REQUIRED TO DETERMINE APPROPRIATE THERAPIST

Referred by: _____ Caseworker: _____ Phone: _____
If CPS -CANS Assessment (check box) ☐ **Required Information for CANS Assessment**
MEDICAID #: _____ PID #_____ REMOVAL DATE: _____

Name of Insured: _____ DOB: _____ SS# of Insured: _____
Employer: _____ Name of Insurance: _____
Policy #: _____ Group #: _____ Phone: _____

Verified by: _____ Deductible: $ _____ Met: Y/N Co-pay: $_____
Max: _____ Other: _____
Mail Forms to: _____

Client seeking help for ☐ Self ☐ Spouse ☐ Children ☐ Other (Specify) Is counseling related to a crime: YES NO
Has child ever been named in a custody agreement/court order: YES NO **IF yes remind client to bring copy**
Reason for request for services: _____

_____

_____

_____

Medical Problems: _____

Previous Counseling: Yes No When? _____ Where? _____
Previous/Current Psychiatric Care: Yes No When? _____ Where? _____ Diagnosis: _____

OFFICE USE ONLY

☐ **Family** ☐ **Individual** ☐ **Marriage** ☐ **Psychosocial** ☐ **Psychiatric** ☐ MCD/MCR ☐ UW ☐ INS ☐ CV ☐ La Fe ☐ CHAMP ☐ CHIP ☐ EAP

Assigned to: _____ Date: _____ Chart #: _____

APPOINTMENT DATE/TIME: _____/_____ ENTERED BY: _____