

Tim F. Fitsimones, M.A., LMHC, CAP

Professional Counseling Services

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Licensed Mental Health Counselor

Certified Addictions Professional

INTAKE ASSESSMENT

NAME:		SOC.SEC. #	SEX M F	DOB	AGE
ADDRESS:			Home Ph: () Work Ph : () Cell or Pager: ()		
CITY - STATE - ZIP			Marital Status: Divorced Single Widowed Committed Relationship Married Separated		
NAME OF INSURED		INSURED SOC. SEC. #	INSURED DOB	YOUR RELATIONSHIP TO INSURED: self spouse child other	
PRIMARY INSURANCE COMPANY	I.D.#	GROUP #	PLAN #	AUTHORIZATION #	
INSURANCE COMPANY ADDRESS		CITY - STATE - ZIP		PHONE NO.	
EMPLOYER Supervisor's name:	OCCUPATION	HIGHEST GRADE IN SCHOOL	Do you think that alcohol is harmful to your health ? Yes No Do you think that tobacco is harmful to your health ? Yes No Do you think that drugs are harmful to your health ? Yes No		
HAVE YOU BEEN IN THERAPY PREVIOUSLY? YES NO If yes please list name of therapist and date					
CREDIT CARD INFORMATION		CREDIT CARD COMPANY NAME		EXPIRATION DATE	
NAME AS IT APPEARS ON CARD			DO WE HAVE PERMISSION TO CHARGE TO THIS ACCOUNT?		
PLEASE DESCRIBE THE PROBLEM(S) THAT BRING YOU TO THERAPY:					
E-Mail address: Work: Home:			(For Therapist use Only)		
Do we have permission to contact you with emailings?			Diagnosis		

LATE CANCELLATIONS & MISSED APPOINTMENTS

I agree to provide 48 hr notice of cancellation for any appointments that I have made. If I do not provide this notice, I agree that I am responsible for payment for the time I reserved and prevented others from being able to use.

_____ Signed

_____ Date