Stress Management Family Counseling Center
300 Boardwalk Drive, Building 5-A
Fort Collins, CO 80525

PATIENT INFORMATION - ADULT

Personal Identification

Name: _____Date: _____/_____/_____
DOB: _____/_____/_____ Gender: _____ Pronoun (optional): _____
Address: _____
City: _____ State: _____ Zip code:_____
E-mail: _____ May we email you (Y/N)? _____
May we: call (Y/N)? leave message (Y/N)?
Telephone: Home: _____ _____ _____
Work: _____ _____ _____
Mobile:_____ _____ _____
Occupation: _____ Employer: _____ Years at work:_____

Marital/relationship status: _____
Partner name: _____ Occupation: _____
Names and ages of children: _____
_____

Billing information

Please check one: ( ) self-pay ( ) Insurance ( ) other: explain _____
Responsible party for payment _____Telephone: _____
Insurance company to be billed _____ Group # _____
Primary insured's name: _____ ID # _____
Primary insured's employer: _____
Primary insured's date of birth: _____/_____/_____ Social security #_____

Treatment information

Referred by: ( ) physician ( ) friend ( ) social media ( ) EAPs ( ) insurance ( ) SMFCC website
( ) other website (list) _____ ( ) other (list) _____
Describe the nature of the problem that brought you here today:
_____
_____
_____
Family physician: _____
List of medical problems: _____
_____
List of medication (if any):_____
_____
_____
Previous mental health treatment ( )Yes ( ) No
Name of therapist, date seen and problem_____
_____

Relative or friend we may contact in case of emergency
Name: _____ Telephone # _____

Who completed this intake form? _____ Relationship to the client: _____