Anne Gordon, LCSW, LMFT, LAC, PC
101 E Broadway, Suite 601, Missoula, Montana 59802
(406) 370-6251
annegordon@annegordontherapy.com

Intake Date

INTAKE FORM

DEMOGRAPHIC INFORMATION

Name:	Date of Birth:	Age:
Address:		
Cell Phone: Ok to leave a message?	Home Phone: Ok to leave a message?	
Email Address:	Social Security Number:	
Race/Ethnicity:	Religious/Spiritual Preference:	
Relationship Status and Length:	Names and Ages Of Children:	
Occupation & Employer:		
Level of Education:	Degree:	
Emergency Contact Information: Name: Phone Number: Address: Relationship to You:		
Who Referred You to Me? May I Have Permission to Thank Them?		

REASON FOR VISIT

Please describe your reasons for seeking therapy at this time:

How long have you been having these difficulties?

What have you done to address these difficulties?

Anne Gordon, LCSW, LMFT, LAC, PC
101 E Broadway, Suite 601, Missoula, Montana 59802
(406) 370-6251
annegordon@annegordontherapy.com

Intake Date

REASON FOR VISIT (Continued)

Please describe any recent major life changes or stressors: Please describe any traumatic or highly stressful experiences *in your lifetime*, to include childhood physical, emotional, or sexual abuse:

MEDICAL INFORMATION

Primary Care Physician (PCP)		
Name:	Phone Number:	
Address:		
Mental Health History (list from current/most recent to past)		
1. Name:	Phone Number:	
Address:		
When:	What For:	Psychologist or Psychiatrist (prescribes)
2. Name:	Phone Number:	
Address:		
When:	What For:	Psychologist or Psychiatrist (prescribes)
3. Name:	Phone Number:	
Address:		
When:	What For:	Psychologist or Psychiatrist (prescribes)
Have you ever been hospitalized for mental health issues? If so when and where?		
Have you ever received mental health diagnosis? If so, what?		
Have you ever attempted suicide in the past? If so, please list, including when, how, and outcome:		

Anne Gordon, LCSW, LMFT, LAC, PC
101 E Broadway, Suite 601, Missoula, Montana 59802
(406) 370-6251
annegordon@annegordontherapy.com

Intake Date

Has anyone in your family ever been diagnosed with or experienced mental health difficulties? If so, please list:

MEDICAL INFORMATION (continued)

Health History
Please describe any medical conditions or health issues:
Please list any medications you are currently taking: Medication Dosage Date Started Purpose

SUBSTANCE USE INFORMATION

	Amount	Frequency	Ages Used
Alcohol			
Drug Use			
Prescription Drug Abuse			
Caffeine			
Tobacco			

FAMILY AND SOCIAL HISTORY

Where were you born and raised?
What was it like for you at home growing up?
Relationship with your: Growing up Currently

Anne Gordon, LCSW, LMFT, LAC, PC
101 E Broadway, Suite 601, Missoula, Montana 59802
(406) 370-6251
annegordon@annegordontherapy.com

Intake Date

Mom:	
Dad:	
Sibling:	
Sibling:	
Sibling:	

FAMILY AND SOCIAL HISTORY (continued)

How would you describe your current romantic relationship (if applicable)?
How would you describe your current partner (if applicable)?
How would you describe your relationship with your children (if applicable)?
How would you describe your current level of social support?

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY	**SECONDARY INSURANCE COMPANY**
Company Name:	Company Name:
Subscriber Name:	Subscriber Name:
Subscriber Date of Birth:	Subscriber Date of Birth:
Subscriber SSN:	Subscriber SSN:
Subscriber #:	Subscriber #:
Group #:	Group #:

Anne Gordon, LCSW, LMFT, LAC, PC
101 E Broadway, Suite 601, Missoula, Montana 59802
(406) 370-6251
annegordon@annegordontherapy.com

Intake Date

AUTHORIZATION OF PAYMENTS

I hereby authorize Anne Gordon to release any information necessary to facilitate the processing of insurance claims submitted on my behalf for services rendered to me. I hereby authorize payment of insurance benefits to Anne Gordon, LCSW, LMFT, LAC, PC, for services rendered to me. I understand that this authorization will remain in effect unless I terminate the authorization in writing. Unless my insurance company stipulates that specific charges or portions thereof are not my responsibility, I understand that I am accountable for full payment on services provided to me.

Signature: _____Date: _____

For Office Use:

Authorization #:	Number of sessions authorized:	
Co-Payment Amount:	Amount Insurance Pays:	Dx: