Counseling Intake

Fax: 616 458-8129 OR Email: helpdesk@hrapsychservices.com

Client Name _____

Address _____

City _____ State _____ Zip _____

Age _____ DOB _____ Gender: M ☐ F ☐

Phone: Home _____ Work _____ Cell _____

Email: _____

Permission to contact via…? ☐Home ☐Work ☐ Cell ☐Email

How did you hear about clinician/HRA?

☐HRA website ☐Hope and Healing website
☐Psychology Today ☐ ☐Phone Book
☐Personal Referral: _____

In general terms, the focus of treatment: _____

Private Pay? Yes ☐ No ☐ [If no, please provide insurance information]

Insurance: _____Policy Holder _____
DOB _____ ID# _____ Group # _____

Have you called your insurance company for authorization? ☐Yes ☐No ☐Not Required

For Minor Clients: The child's parents are: ☐Married ☐Separated ☐Divorced ☐Single Parent
Mother's Name _____ Father's Name _____
Are both parents aware that treatment has been requested? Yes ☐ Not Required ☐

Name of person requesting the appointment: _____