Dr. Sharlene Bird

CLIENT INTAKE FORM

Name: ____ Date: _________________

DOB: ____/______/______ Age: _____ Social Sec. # ____________________

Insurance carrier (if applicable): _____________________________

ID #: __________________ Group #: ____________________ Policy #:_________________

Name of Insured:______________________DOB:____________Employer:________________

Insured ID #: _______________________ Relationship to you: __________________________

Home Address:____

City/State:__________________________ ZIP: ______________

Home #: ___________________ Cell #: ___________________ Work #: __________________
May I leave a message at your home#? Yes No Work #? Yes No Cell #? Yes No

Email address: ________________________________

Employer: _______________________________ Profession/Occupation___________________

Marital Status:(Circle One) Single Married Partnered Separated Divorced Widowed (Yrs______)

Spouse/Partner/Significant Other Name: ____

Work #: ____________________ Cell #: ____________________

Emergency contact Name: _______________________ Relationship: _____________________

Address: _______________________________ City/State: _______________ ZIP: _________

Phone #: __________________

Office Use:		
Tx Modality: ____________________	Fee: _______________	DX: ___________________

Phone: (212) 582-3614 Website: www.drsbird.net

Current Medications: Please list with dosage. ____

____

Previous Counseling/Therapy? Yes No If Yes, when & duration? ___________________

Where and with whom? ____

Does anyone in your family have any history of mental illness (such as depression, anxiety, substance abuse, etc.)? If so, please list ____

____

	Poor				Excellent
How do you sleep at night?	1	2	3	4	5
How is your nutrition?	1	2	3	4	5
Do you drink alcohol?	Yes	No	How much? ___________________		
Do you drink coffee?	Yes	No	How much? ___________________		
Do you smoke cigarettes?	Yes	No	How much? ___________________		

Do you smoke pot or use other recreational drugs? Yes No Frequency_______________

Does any of the following items apply to your concern today?

_____Anger/temper

_____Anxiety

_____Depression

_____Family or business consultation

_____Fearfulness

_____Lifestage issues

_____Marital issues

_____Multicultural issues

_____Problems with social relationships

_____Sexual Abuse/Trauma

_____Sexual Concerns/Dysfunction

_____Thoughts of hurting yourself or others

_____Trouble making decisions

_____Other (Specify)__________________

Brief summary of reason for seeking treatment: ____

____

____

Whom were you referred by? ____

I understand that Dr. Bird has chosen to work without insurance assignment or third party payment. Reimbursement for services is strictly between myself and my insurance carrier. I understand that insurance coverage is not guaranteed and I am responsible for full payment of services rendered.

Signature_____________________________________Date______________________