

The Arbor Center Intake Form

Demographic Information

Date _____

Name _____ Social Security _____

Address _____

City _____ State _____ ZIP _____

Phone numbers

Home _____ Cell _____ Work _____

Date of Birth _____ Age _____ Single Married Other M F

Referred by _____ Phone Number _____

Current Medication _____

Previous Therapist Name _____ Phone _____

Previous Mental Health Hospitalization Dates _____

Insurance Information

Insurance Company _____ Phone _____

Policy Number _____ Group Number _____

Policy Holder Name _____ Date of Birth _____

M F Social Security _____ Address _____

Emergency Information

Primary Care Physician _____ Phone _____

Name of Emergency Contact _____ Phone _____

Relationship to Client _____