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Client Intake Form

Demographic Information

Date: _____

Name: _____ Date of Birth: _____ Age: _____

Nickname: _____ Gender: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Only list phone numbers and email addresses where you are comfortable being reached.

Home #: _____ Work #: _____ Cell #: _____

Primary Email: _____ Alternate Email: _____

Education (circle highest level completed): High School Undergraduate Graduate Doctorate

Occupation: _____ Employer: _____

Insurance Information

Note: We do not directly participate with any insurance company. The client is solely responsible for all payments of services and interactions with insurance company.

Name of Insurance Company: _____ Phone: _____

Policy #: _____ Group #: _____ Name of Policy Holder: _____

Address of Policy Holder (if other than above): _____

Phone # of Policy Holder: cell _____ work _____

Relationship to Policy Holder: _____ Date of Birth Policy Holder: _____

Soc Security # Policy Holder: _____ Employer of Policy Holder _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Name: _____

Medical Information

Primary Care Physician: _____ Phone: _____

Have you seen your Primary Care Physician in the past 12 months: Yes No
(We strongly recommend that all clients have a physical examination at least every 12 months.)

Name and phone number for other physicians you are currently seeing:

Please list the medications you are currently taking:

Medication	Dose	Reason

Please list any current medical problems

Family Information

Marital status: Single Dating Married Separated Divorced Widowed Other _____

List the name, age, and relationship of all people living within your home

List the name and age of children not living in your home

Name	Age	Relationship

Name	Age

Name: _____

Counseling

What has brought you into counseling?

Previous counseling? Please list approximate dates and name of counselor

Previous hospitalizations for these conditions? Please list approximate dates and facility

Do you have any other concerns today?

Faith

Particular religious denomination/affiliation: _____

How involved are you in your faith:

Not involved at all	Attend services occasionally	Attend services weekly	Attend services more than once per week
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Would you want your therapist to integrate faith in planning and implementing your treatment?

Yes _____ No _____ Unsure _____

Referral

How did you hear about us?
