Brina Teitz Mental Health Counseling
(347) 860-9099 | brinateitzLMHC@gmail.com

Intake Form for Adult Patients

Identifying Information

Name: _____ DOB: _____ Age: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip Code:_____

Phone Number: _____

Email Address:_____

Ethnicity: _____ Religion: _____ Sexual Orientation: _____

Gender Identity: _____ Preferred Gender Pronouns: _____

Occupation: _____ Employer/School: _____

Education: _____

Relationship Status:

▢ Single ▢ Cohabiting ▢ Married ▢ Never Married ▢ Divorced
▢ Separated ▢ Widowed

Children (if applicable): _____

Referred to therapy by: _____

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Emergency Contact Information

Name of Emergency Contact: _____

Phone Number: _____

Email Address: _____

Relationship to Client: _____

I, _____, agree for therapist to contact the above
(print name)
person in the case of an emergency.

Signature of Client/Guardian: _____ Date: _____

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Insurance Information

Insurance Company: _____

Patient's ID #: _____

Policy Group Number: _____

Policy Holder Name: _____

Policy Holder DOB:_____

Policy Holder SSN: _____

Relationship to Insured: _____