Michael Robbins Counseling
Professional Counseling
Intake Information

Michael Robbins LIMHP, NCC
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Please complete the following information. Information provided here is kept confidential.

Name: _____
(First) (Middle Initial) (Last)

Name of parent or guardian (if you are under age 18):

_____
(First) (Middle Initial) (Last)

Gender: ☐ Male ☐ Female

Relationship: ☐ Single ☐ Married ☐ Partnership ☐ Separated ☐ Divorced ☐ Widowed

Date of Birth: _____ Age: _____

Address:_____
(Street and Number)

_____
(City) (State) (Zip code)

Home Phone: _____ Cell Phone: _____
Work Phone: _____

E-mail address: _____

Preferred way to be contacted? _____

Current Employment Status: ☐ Employed Full-time ☐ Employed Part-time ☐ Self-employed
☐ Not currently working ☐ Disabled ☐ Retired ☐Other _____

Occupation: _____

Employer: _____

Insurance Information

[Leave blank if same as above and skip to insurance questions.]

Last Name:_____ First:_____ Middle Initial: ___

Mailing Address (if different from above):

Street Address: _____ City: _____State: ___ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Social Security Number: _____ Relationship: _____

Primary Insurance: ___ I do/ ___ I do not want to file claims with this company.

Insurance ID: _____ Insurance Group: _____

Secondary Insurance: ___ I do/ ___ I do not want to file claims with this company.

Insurance ID: _____ Insurance Group: _____
[Please present your insurance card(s) to therapist at beginning of session for photocopying.]
Referral Information

Referred by: _____ Reason: _____

Primary reason for seeking services: _____