THE COUNSELING SOURCE, INC.

TELEHEALTH INTAKE FORM

10921 Reed Hartman Hwy, Suite 133, Cincinnati, OH 45242

Phone: (513 984-9838 or (800) 618-0688 Fax: (513) 984-8075 or (800) 738-9854

PLEASE TYPE or PRINT CLEARLY and COMPLETE ALL FIELDS

Referral Date _____ **Physician/Referring Party** _____

Phone _____ **Email** _____

_____ **ROUTINE: Appointment scheduled within 2 weeks**

_____ **PRIORITY: Appointment scheduled within 1 week, serious, non-urgent, symptomology displayed**

***Upon verification of insurance we will contact you to discuss any financial responsibility you have and send consents for your signature. Once received, we will make an effort to follow up within 3 business days with an appointment time.**

Client Name _____ **Phone**_____ **Gender: Female** ____ **Male**____

Date of Birth _____ **Social Security #** _____ **Email**_____

Address _____ **City** _____ **State OH Zip**_____

Guardian/Parent: No___ **Yes**___ **Name** _____ **Phone#**_____

Address _____ **City**_____ **State**____ **Zip**_____

Email _____ **Relationship**_____

OHIO MEDICAID: No____ **Yes**____ **Medicaid (MMIS) # (12 Digits)**_____

MCO Name (if applicable e.g. Caresource) _____ **MCO MEMBER ID** _____

PRIVATE INSURANCE (PI) PROVIDER _____ **PI POLICY #** _____

PI POLICY HOLDER NAME _____ **PI POLICY HOLDER DATE OF BIRTH**_____

Preferred Therapist: Female ____ **Male** ____ **Either**____ **Days/Times Available** _____

_____

PRESENTING PROBLEMS ***Circle all that apply***

1. Suicidal Statements/Attempts	6. Appetite Problems	11. Emotional Outbursts	16. Problem Behaviors
2. Acting Sexually Inappropriate	7. Being Depressed	12. Impulsivity	17. Psychotic Thinking
3. Adjustment Difficulties	8. Being Withdrawn	13. Inattention	18. Relationship Problems
4. Anger Problems	9. Sleep Patterns	14. Substance Abuse	19. Thought Distortion
5. Anxiety	10. Fears	15. Mood Swings	20. Worries

21. Other_____

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