Tammy A. Summers, M.Ed., LPC
(919) 659-5570 office (919) 782-4770 fax

Intake Date: _______________ Diagnosis Code: __________________
File Ins: __________________
Referred By: _______________ MCC: __________________

Patient Information

Name ____ **Phone#** ________________________________
(home) (cell)

Home Address ____
(street) (city) (state) (zip)

Age ________ Date of Birth ___________ Sex _____ SSN ___________________________________

Employer ____ Work Ph# ____________________________________

Spouse/Parent ____ Ph# ____________________________________

Marital Status ____________
If Married, Mo/Yr Married ________ If Divorced or Separated, Mo/Yr Divorced or Separated __________

Education _____________________ Children: Yes / No

If yes, Names and Ages of Children ____

School currently attending ___________________________ Grade __________________

Religious Preference __________________________ Church Affiliation ____________________

Primary Care Physician ___________________________________

Current Medications & Dosage ____

Past/Current Medical Problems ____

Date of Last Physical __________ Blood Panel Taken Yes / No

Describe any head injuries ____

Previous counseling? Yes / No If yes, dates ______________ Therapist _____________________________________

Insurance Information

Primary Insurance ________________________ ID# ____________ Group# ___________ Co-pay ________________
Deductible _________ Insurance Ph# _________________ Mental Health Benefits Ph #___________________________

Policy Holder ____________________________ Policy Holder DOB ___________ Relation to Client ________________

Employer ____ Work Ph # ____

Emergency Contact _________________________________ Phone Ph# ____

Person Responsible for Payment ____

(address if different than above) ____