**INTAKE FORM**

#### Please email admin@mcgraleandassociates.com and let us know that you would like to send us the completed form. We will reply to your email with a HIPAA compliant email that you can reply to with the completed intake form attached. You can also fax it to 855-730-1471

**TODAY’S DATE**: Click or tap to enter a date.

**REQUESTING SITE**: Click or tap here to enter text.

**RENDERING PROVIDER**: Click or tap here to enter text.

 **PATIENT INFORMATION**

**CHILD’S NAME (FIRST/ LAST):** Click or tap here to enter text.

**PARENT/GUARDIAN:** Click or tap here to enter text.

**PHONE NUMBER:** Click or tap here to enter text.

**DATE OF BIRTH:** Click or tap to enter a date.

**STREET ADDRESS (STREET, CITY, STATE, ZIPCODE):** Click or tap here to enter text.

**GENDER:** Click or tap here to enter text.

**DIAGNOSIS:** Click or tap here to enter text.

**SERVICES REQUESTED:** Click or tap here to enter text.

**DIAGNOSING PHYSICIAN:** Click or tap here to enter text.

**PRIMARY CARE PHYSICIAN:** Click or tap here to enter text.

**PRIMARY CARE PHYSICIAN CONTACT #:**Click or tap here to enter text.

**DIAGNOSED BY:** Click or tap here to enter text.

**DATE OF DIAGNOSIS:** Click or tap here to enter text.

**AGE OF DIAGNOSIS:** Click or tap here to enter text.

**ALLERGIES:** Click or tap here to enter text.

**PREVIOUS AND CURRENT INTERVENTIONS**

**(Speech Therapy, Occupational Therapy, Behavioral Therapy, other services)**

**INTERVENTION 1:** Click or tap here to enter text.

**PROVIDER:** Click or tap here to enter text.

**DATES OF INTERVENTION:** Click or tap here to enter text.

**INTERVENTION 2:** Click or tap here to enter text.

**PROVIDER:** Click or tap here to enter text.

**DATES OF INTERVENTION:** Click or tap here to enter text.

**PLEASE PROVIDE A DIAGNOSTIC REPORT FROM YOUR CHILD’S PHYSICIAN:**

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**INSURANCE INFORMATION**

**PRIMARY INSURANCE**

**New Insurance** [ ]  **Old Insurance** [ ]

**INSURANCE COMPANY NAME:** Click or tap to enter a date.

**TERMED DATE:** Click or tap to enter a date.

**SUBSCRIBER’S NAME:** Click or tap here to enter text.

**BIRTH DATE:** Click or tap to enter a date.

**SUBSCRIBER’S S.S NO.:** Click or tap here to enter text.

**POLICY NO:** Click or tap here to enter text.

**EMPLOYER:** Click or tap here to enter text.

**PATIENT’S RELATIONSHIP TO SUBSCRIBER:** Click or tap here to enter text.

**SECONDARY INSURANCE**

**New Insurance** [ ]  **Old Insurance** [ ]

**INSURANCE COMPANY NAME:** Click or tap to enter a date.

**TERMED DATE:** Click or tap to enter a date.

**SUBSCRIBER’S NAME:** Click or tap here to enter text.

**BIRTH DATE:** Click or tap to enter a date.

**SUBSCRIBER’S S.S NO.:** Click or tap here to enter text.

**POLICY NO:** Click or tap here to enter text.

**EMPLOYER:** Click or tap here to enter text.

**PATIENT’S RELATIONSHIP TO SUBSCRIBER:** Click or tap here to enter text.

**PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD**

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[ ] The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Name of Provider or insurance company to release any information required to process my claims.

**PATIENT/GUARDIAN SIGNATURE: DATE:**

Click or tap here to enter text. Click or tap to enter a date.

**CLIENT INTAKE FORM BEHAVIORAL INTERVENTION SERVICES**

**Background Information History**

**FATHER’S NAME:** Click or tap here to enter text.

**OCCUPATION:** Click or tap here to enter text.

**MOTHER’S NAME:** Click or tap here to enter text.

**OCCUPATION:** Click or tap here to enter text.

**HOME ADDRESS:** Click or tap here to enter text.

**HOME PHONE:** Click or tap here to enter text.

**MOM WORK/CELL:** Click or tap here to enter text.

**MOM EMAIL:** Click or tap here to enter text.

**DAD WORK/CELL:** Click or tap here to enter text.

**DAD EMAIL:** Click or tap here to enter text.

**SIBLINGS:**

**NAME:** Click or tap here to enter text.

**SEX:** Click or tap here to enter text.

**AGE:** Click or tap here to enter text.

**Diagnosis (if any)** Click or tap here to enter text.

**NAME:** Click or tap here to enter text.

**SEX:** Click or tap here to enter text.

**AGE:** Click or tap here to enter text.

**Diagnosis (if any)** Click or tap here to enter text.