Embark Mental Health

3240 E Bison Trail, Suite 200
Sioux Falls, SD 57108
P: (605) 961-4746 **F:** (605) 961-4747

Health Intake Form

Name: _____
First Middle Initial Last

Address: _____

City: _____ State: _____ Zip: _____

SSN# (responsible party): _____ Birth Date: _____

Marital Status: _____Single _____Married _____Separated _____Divorced _____Widowed

Student: _____Full time _____Part time Gender: M F Other: _____

Email Address: _____ Work Phone: _____

Home Phone: _____ Cell Phone: _____

Employer: _____

Person to Contact (circle one): Spouse or Parent(s)

Name(s): _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Primary Insurance Information/Authorization:

Primary Insurance: _____

ID Number: _____

Group Number: _____

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Name of Policy Holder:_____Birth Date:_____

Relationship to Client: _____Phone: _____

Address of Policy Holder: _____

City: _____State: _____Zip: _____

Employer of Policy Holder: _____

Secondary Insurance: _____

ID Number: _____Group Number: _____

Name of Policy Holder: _____

I hereby authorize Embark Mental Health, LLC to release necessary information to insurance carriers concerning my diagnosis and treatment in order to process my claims. I hereby authorize direct payment to Embark Mental Health, LLC from insurance carriers for services rendered if my account is not paid in full. I permit a copy of this authorization to be used in place of the original copy.

Signature of Policy Holder: _____

Health Information of Client:

Present health: ____Excellent ____Good ____Fair ____Poor

Significant health concerns: _____

Current medications:

Drug/Dosage: _____Drug/Dosage: _____

Drug/Dosage: _____Drug/Dosage: _____

Drug/Dosage: _____Drug/Dosage: _____

Do you smoke?: ____Yes ____No Packs/Day/Longevity: _____

Do you use alcoholic beverages?: ____Yes ____No If so, how often?: _____

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Physician Information/Authorization:

Family Physician: _____ Clinic: _____

I hereby authorize Embark Mental Health, LLC to release records and/or information about my treatment to my physician for the purpose of treatment, planning, and coordinating psychotherapy with my physical health care needs. I may withdraw this consent at any time in writing or verbally advising my therapist.

Physician Name: _____

Signature of Client: _____ Date: _____

Signature of Parent or Guardian (if applicable): _____ Date: _____

Client's Intake Questionnaire

What are your concerns that you want to address in counseling?

_____

_____

_____

_____

What are your goals for counseling?

_____

_____

_____

_____

How did you hear about us?

_____

_____

_____

_____