Life Haus
Therapeutic Solutions LLC

Instilling hope in life by promoting Mental Health and Wellness of Mind, Body, Spirit

DOB: ____________________ DATE: ____________________
SS#: ____________________ NAME OF CALLER: ____________________
MARITAL STATUS: ____________________ AGE: ____________________
NAME OF CLIENT: ____________________ CELLPHONE: ____________________
ADDRESS: ____________________ HOME PHONE: ____________________
____________________ WORK PHONE: ____________________
REFERRED BY: ____________________ REFERRAL PHONE: ____________________
ADDRESS: ____________________ E-MAIL: ____________________
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TYPE OF SERVICE (PLS. CIRCLE): INDIVIDUAL / COUPLE / FAMILY / GROUP

SUICIDAL/HOMICIDAL IDEATION: ( ) YES ( ) NO

SUBSTANCE ABUSE: ( ) YES ( ) NO

SLEEP/APPETITE PROBLEMS: ____________________

PRESENTING PROBLEM(S): ____________________

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PREVIOUS TREATMENT/HOSPITALIZATON: ____________________

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MEDICATION: ____________________

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HOURS AVAILABLE FOR APPOINTMENT: ____________________

INTAKE INTERVIEW: (DATE): ____________________ (TIME): ____________________

IF INTAKE INTEVEIW NOT SCHEDULED, REASON: ____________________

DATE OF INITIAL PHONE CONTACT TO ARRANGE APPT.: ____________________

REASON FOR WITHDRAWAL: ____________________

FORM OF PAYMENT: ____________________

NAME OF INSURANCE: ____________________

SPECIAL CONSIDERATIONS: ____________________

Psychotherapy, Mental Health, Autism Spectrum, Weight Management, and Wellness Center

600 South Livingston Avenue, Suite 106 • Livingston, New Jersey 07039 • Tel: 908-494-2338 • Fax: 908-925-6111
www.life-haus.com • www.beyondmindbodywellness.com • E-mail: welcome@life-haus.com