

## Molenaar Counseling Intake Form

Client Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work/Cell Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Employer or School Name \_\_\_\_\_

List any medications you are taking \_\_\_\_\_

Please fill out the following section completely so we are able to file your insurance forms for you.

Name of Insured \_\_\_\_\_ Date of birth \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Primary Insurance Company \_\_\_\_\_

Insurance Phone \_\_\_\_\_

Claims Address \_\_\_\_\_

ID # \_\_\_\_\_ Group# \_\_\_\_\_

Secondary Insured \_\_\_\_\_ Date of birth \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_

Claims address \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

### CONSENT TO RELEASE INFORMATION

1. I consent to the release of any medical information necessary to process claims associated with my treatment.
2. I authorize payment of medical benefits to Matthew Molenaar LCSW
3. A copy of this consent may be used in stead of the original.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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(773) 771-9189  
molenaarcounseling.com

**Please continue to the next page.**

## SYMPTOM CHECKLIST

Please rate the degree to which you have been experiencing the following problems during the PAST MONTH by making an "X" in the appropriate box. If you are not experiencing a certain symptom that is listed then leave the boxes for that symptom empty.

Symptom	Sometimes	Often	Always
Anxiety/Nervousness			
Depression			
Fears/fearfulness			
Angry outbursts (temper)			
Eating problems			
Sleep problems			
Fatigue			
Alcohol and/or drug problems			
Stress			
Work/school problems			
Family problems			
Child-rearing problems			
Problems getting along with others			
Violence			
Health problems			
Legal problems			
Financial problems			
Sexual and/or Pornography problems			