Jennifer W. Walken, Ed.D. P.A.

Licensed Psychologist
Licensed Marriage & Family Therapist

Intake Date ________________________

Referred By ________________________

DSM IV ____________
File Ins ____________
MCC ____________

Patient Information

Name ____________________________________ Phone# ____
(home) (cell)

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

Age ________ Date of Birth ________________Sex_______ SSN___________________________________

Employer _____________________________________Work Phone ____________________________________

Spouse/Parent __________________________________ Phone____

Marital Status ______________ Since what date ____________________ Education _____________________

Names and Ages of Children ____

School ____ Grade _____________________________

Religious Preference ______________________ Church Affiliation ______________________________________

Primary Family Physician ________________________ Current Medication & Dose ______________________

Past/Current Medical Problems ____

____

Have you received previous counseling? __Y __ N If yes, dates _________ From Whom __________________

Date of Last Physical _____________________________________ Blood Panel Taken? ____yes ______no

Describe any Head Injuries? ____

Insurance Information

Primary Ins. Company _______________________________ Subscriber ID# _____________________________

Group# ______________________________ Deductible ______________________ Copay ________________

SSN of Insured ___________________________Mental Health Benefits Phone# _________________________

Policy Holder _____________________ Policy Holder DOB __________ Relation to Client _________________

Employer _______________________________ Work# ____

Emergency Contact _______________________________ Phone _____________________________________
(home) (cell/work)

Person Responsible for Payment ____