



CORNER CANYON COUNSELING & PSYCHOLOGICAL SERVICES

248 East 13800 South, Suite 4
Draper, UT 84020
Phone: 801.816.1801 Fax: 801.501.0249

PATIENT INTAKE FORM

Date _____

Patient Information

Name _____ Social Security Number _____
Date of Birth _____ Sex _____ Age _____
Street Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Cell Phone _____
Email Address _____
Occupation _____ Employer _____
Marital Status _____ Name of Spouse/Partner _____
Occupation of Spouse/Partner _____
Work Phone of Spouse/Partner _____
Names and Ages of Children, if any _____

Insurance Information

Information on Primary Insurance Company

Insurance Company _____
Policy Holder's Name _____ Social Security Number _____
Policy Holder's Address _____
Policy Holder's Date of Birth _____ Insurance ID _____
Policy Holder's Employer _____
Relationship of Patient to Policy Holder _____
Address of Insurance Company _____
Phone Number of Insurance Company _____

We do not bill secondary insurance but will be happy to provide you with necessary information so that you can complete your billing to them.

Email Address where statement should be sent _____

Physical Address where statement could be sent _____

Medical and Counseling Information

Primary Care Physician _____

Psychiatrist _____

Date of Last Physical Examination _____

List health problems you have had in the past _____

List health problems you are experiencing now _____

List any prescription medications, herbal remedies, over-the-counter medications, or food supplements that you are currently taking:

Medication	Dosage	Taken for?	Prescribing Physician

Have you experienced any adverse reactions to medications? Please list the medication and the reaction:

Medication	When taken?	Adverse Reaction

List psychological medications you have taken in the past:

Medication	When taken?	Adverse Reaction

If you have received outpatient psychotherapy in the past, please list the names of those who have provided that service.

Psychotherapist	Dates seen	Diagnosis

If you have received inpatient treatment in the past for psychiatric or psychological treatment, list the location and dates of the treatment.

Hospital	Dates of hospitalization	Diagnosis

Please explain why you are seeking professional help at this time:

Please explain any recent event/s that may contribute to present symptoms.

May we remind you by phone or email of upcoming appointments and let you know of openings when you need an appointment? _____

What email may we use for appointment reminders? _____

If you prefer to be called, what number(s) should we use to reach you? _____

May we leave voice mail regarding appointments? _____

May we leave messages regarding your appointments with others who may answer your number?

Signature _____

Reminder e-mails and phone calls are a courtesy. At times, we may be unable to provide this service. Remember that you are ultimately responsible for your scheduled appointments.
