Exhale Behavioral Health
2913 Valley Avenue, Suite 125
Winchester, VA 22601
Phone: 540-692-9428 Fax: 540-750-4046

INTAKE INFORMATION FORM

Please PRINT and fill out the following information for my confidential records:

Intake Date: _____

Name: _____ Date of Birth: _____ Age: ___
(First) (Last)

Sex: _____Female _____Male Marital Status: _____

Social Security #: _____-___- _____

Address: _____

_____
City State Zip Code

Home Phone: _____ OK to leave message? _____

Work Phone: _____ OK to leave message? _____

Cell Phone: _____ OK to leave message? _____

Email: _____
Is it OK that I contact you via email? ◯Yes ◯No

Preferred method of contact (circle one): ◯Home ◯Work ◯Cell ◯Email

Referred by: _____
OK to let referral know we made contact? ◯Yes ◯No

Employer/School: _____

Grade in School: _____

Please indicate ALL that apply (optional):

Sexual Orientation: (please circle if applicable)
Gay ☐ Lesbian ☐ Bisexual ☐ Questioning ☐ Heterosexual ☐ Other _____

Ethnic/Cultural Background:
_____ American Indian or Alaskan Native
_____ Black or African American
_____ Hispanic/Latino
_____ Asian
_____ Native Hawaiian or Other Pacific Islander
_____ White (Includes Middle Eastern & North Africa)
_____ Two or more races

Spiritual Orientation: (please circle if applicable)
Atheist ☐ Agnostic ☐ Buddhist ☐ Christian ☐ Jewish ☐ Muslim ☐ UU ☐ None ☐
Other _____

Please briefly describe the concerns you would like help with:

_____

_____

_____

Have you been in therapy previously? If so, please let me know where, when, and with whom you have worked:

_____

_____

_____

Are you currently taking any medications? If yes, which ones and what is the dosage?

_____

Have you had a physical in the last 12 months? ◯ Yes ◯ No
Please indicate your primary care doctor's name: _____

Parent/Guardian Information (if applicable)

Name: _____ Relationship to Client: _____

Name: _____ Relationship to Client: _____

Address: _____
Street City State Zip Code

Home Phone: _____ Date of Birth: _____

Work Phone: _____

Cell Phone: _____

Preferred method of contact (circle one): Home ☐ Work ☐ Cell ☐

Billing Information

Responsible Party Information (if different from client)

Name: _____ Relation to client: _____

Address: _____

Phone #: _____

Insurance Information

Insurance Carrier: _____

Name of Insured: _____

Date of Birth of Insured: _____

ID Number: _____ Group Number: _____

Phone number on Back of the Card: _____