# DR. DEBRA N. BROSIUS, PSY.D., LLC

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## INTAKE INFORMATION FORM

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

Intake Date: _____

Name: _____

Date of Birth: _____ Age:_____

Gender _____

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

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 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. Previous diagnosis?
_____
_____
_____

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:_____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

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

**Billing Information:**

Responsible party (if different form the client):_____

Address:_____

Phone_____

**Insurance Information**

Insurance Carrier_____

Name of Insured_____

Date of Birth of Insured_____

ID Number_____

Group Number_____

Phone Number (on the back of card)_____

**Please provide a copy of the front and the back of your insurance card**