Paula Shulman, LICSW – CASAC – LADC

Po Box 814 Arlington, Vermont 05250

Phone: (802) 379-5117 Fax: (802) 881-0168

Intake Form

I. Identifying Data

Date ____________________

Name ____ Telephone ______________

Address ____ Date of Birth _____________

Employer/School ____________________________________ Referral Source ___________

Primary Care Physician _____________________________ Phone __________________

Emergency Contact _________________________________ Email __________________

II. Insurance Information

Primary Insurance Company ____

ID# ___________________________ Group# ____________________________________

SS# ___________________________ Deductible _________ Co-pay ____________

Name of Subscriber ____________________ Date of Birth _________________________

Employer _____________________________ Do you have another insurance? __________

III. History of Counseling for Mental Health and/or Substance Abuse

Provider	Dates Seen	Problem	Discharge Recommendations

IV. Briefly Summarize Current Stressors and what brings you to therapy

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V. Medications/Current Illness/Hospitalizations

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VI. Questions

Are you concerned about your or someone else's drug/alcohol use? ____________________

Are you concerned about your or someone else's Mental Health and/or safety? ___________

Are you worried about violence from others or toward others? _______________________

Are you currently involved in legal issues? ______________________________________

*I authorize payment of medical benefits to Paula Shulman for services rendered.

Signature _________________________________ Date _________________________

*I authorize P. Shulman to leave Text messages for appointment reminders on my phone I understand that use of these messages are for appointments only. And I have been informed of procedures for emergency/crisis support.

Signature _________________________________ Date _________________________