Tri-City Psychology Services

Changing minds, Transforming lives

CONFIDENTIAL

Intake Information

Date : ----------

Client Name : ---------- Date of Birth : ----------

Address : ---------- Age : ----------
(or Claim Number)

Telephone (home) ---------- (work) ---------- email ----------

Partners Name : ---------- Date of Birth : ----------

Partner's Address : ---------- Age : ----------
(if different from above)

Referred By : ---------- Tel: ----------

Physician : ---------- Tel: ----------

Presenting Concerns: ----------

Extended Health : ---------- Policy Number : ----------

S.I.N.: ---------- Group Number : ----------

WCB ---------- ICBC: : ----------

Amount Of Coverage: ---------- Dr. Referral Needed : ----------

Appointment Date : ---------- Psychologist : ----------