

**Jennifer W. Walken, Ed.D. P.A.**  
Licensed Psychologist  
Licensed Marriage & Family Therapist

Intake Date \_\_\_\_\_

DSM IV \_\_\_\_\_

Referred By \_\_\_\_\_

File Ins \_\_\_\_\_

MCC \_\_\_\_\_

**Patient Information**

Name \_\_\_\_\_ Phone# \_\_\_\_\_  
(home) (cell)

Home Address \_\_\_\_\_  
(street) (city) (state) (zip)

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ SSN \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Spouse/Parent \_\_\_\_\_ Phone \_\_\_\_\_

Marital Status \_\_\_\_\_ Since what date \_\_\_\_\_ Education \_\_\_\_\_

Names and Ages of Children \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Religious Preference \_\_\_\_\_ Church Affiliation \_\_\_\_\_

Primary Family Physician \_\_\_\_\_ Current Medication & Dose \_\_\_\_\_

Past/Current Medical Problems \_\_\_\_\_

Have you received previous counseling? \_\_Y\_\_ N If yes, dates \_\_\_\_\_ From Whom \_\_\_\_\_

Date of Last Physical \_\_\_\_\_ Blood Panel Taken? \_\_yes\_\_ \_\_no\_\_

Describe any Head Injuries? \_\_\_\_\_

**Insurance Information**

Primary Ins. Company \_\_\_\_\_ Subscriber ID# \_\_\_\_\_

Group# \_\_\_\_\_ Deductible \_\_\_\_\_ Copay \_\_\_\_\_

SSN of Insured \_\_\_\_\_ Mental Health Benefits Phone# \_\_\_\_\_

Policy Holder \_\_\_\_\_ Policy Holder DOB \_\_\_\_\_ Relation to Client \_\_\_\_\_

Employer \_\_\_\_\_ Work# \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_  
(home) (cell/work)

Person Responsible for Payment \_\_\_\_\_