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INTAKE INFORMATION FORM

Date: ____/____/____

Name: _____

Last Name	First Name	Middle Initial
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Address: _____

Street	City	State	Zip
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Date of Birth ____/____/____ **Age:** _____ **Partner Status:** _____

E-mail Address: _____
Can I leave confidential message? Please circle YES NO

Home Telephone: _____ **Work Telephone:** _____
Can I leave confidential message? Please circle YES NO Can I leave confidential message? Please circle YES NO

Emergency Contact: _____

Relationship to you: _____ **Telephone Number:** _____

Occupation: _____ **Length with Current Employer:** _____

Employer or Institution Name: _____

Paying for Services, (please circle) **Self Pay** **Insurance** **EAP**

If Using Insurance or EAP:

Insurance Company of EAP Plan Name: _____

Insured's Group Number: _____

Phone Number for Insurance Benefits or EAP: _____

Insured's Name: _____ **Insured's SSN:** ____/____/____
(if different from the name above)

Insured's Date of Birth: ____/____/____

Insured's Employer's Name: _____
(If different from the name above)

Insured's Address: _____
(If different from the name above) **City** **State** **Zip**

Referred By: _____