Across the Bridge, LLC.
Counseling for adolescents and adults

INTAKE FORM

Name: _____ Date of Birth: _____

Phone: Home/Cell (_____)_____ __ (May I leave a message/txt? Yes/No)
Alternative #: (_____)_____ (May I leave a message/txt? Yes/No)
Email: _____

Address: _____

Emergency Contact: _____ Relationship:_____
Emergency Contact number: _____

Insurance Co._____ ID#: _____
Name of Insured:_____ Insured DOB: _____

Medications: (Please list all of the medication that you are currently taking.)
_____
_____
_____
_____

The reason for the treatment:
_____
_____
_____

Have you received therapeutic treatment in the past? (including hospitalization, PH,IOP, and outpatient) Yes/No
If yes, Date: _____ The provider or program: _____
Date: _____ The provider or program: _____
Date: _____ The provider or program: _____

What would you like to accomplish from the treatment:
_____
_____
_____
_____

Referred by _____

141 Wall St. Princeton, NJ 08540
609.917.4011
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yinzana@gmail.com

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