ELAYNE & JAMES SCHOKE JEWISH FAMILY SERVICE OF FAIRFIELD COUNTY

SCHOKE JEWISH FAMILY SERVICE INTAKE APPLICATION

Today's Date: _____/_____/_____ **Referral Source:** _____

Patient's Name: _____

Date of Birth: _____/_____/_____ **Is the patient a minor (Under age 18):** ☐ Yes ☐ No

If the patient is a minor, please provide the name and phone number of legal guardian:

Name: _____ **Phone:** _____

Address: _____

_____

Phone
Home: _____ **Work:** _____ **Cell:** _____

At which number may we leave a message? ☐ Home ☐ Work ☐ Cell

Email: _____

Sex: ☐ Male ☐ Female ☐ Non-binary **Marital Status:**

Do you have any children? ☐ Yes ☐ No

Race/Ethnicity:
☐ White ☐ Black or African American ☐ Hispanic/Latino ☐ Asian

☐ American/Indian ☐ Alaska Native ☐ Native Hawaiian or other Pacific Islander

Other _____

Religion:

Occupation: ☐ Student ☐ Unemployed ☐ Employed ☐ Retired

Reason for referral:

_____

_____

_____

Current therapist/ counselor: _____ **Phone #:** _____

Are there any specific accommodations we should know about prior to treatment?

_____

_____

Please check off any symptoms you are currently experiencing:

- ☐ Depressed mood
- ☐ Increased irritability
- ☐ Concentration/forgetfulness
- ☐ Change in libido
- ☐ Sleep pattern disturbances
- ☐ Excess worry
- ☐ Avoidance
- ☐ Suspiciousness
- ☐ Decrease need for sleep
- ☐ Increase in risky behavior
- ☐ Hallucinations
- ☐ Crying Spells
- ☐ Fatigue
- ☐ Unable to enjoy activities
- ☐ Change in appetite
- ☐ Excess guilt
- ☐ Anxiety/panic attacks
- ☐ Racing thoughts
- ☐ Impulsivity
- ☐ Mood swings
- ☐ Flashbacks

Have you ever had feelings or thoughts that you didn't want to live? ☐ Yes ☐ No

Do you currently feel like you don't want to live? ☐ Yes ☐ No

Are you currently taking any prescribed medications? ☐ Yes ☐ No

Drug Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

Continue to page 3 for Insurance Information

Insurance Information:

Do you currently have insurance? ☐ Yes ☐ No

If yes, what insurance do you have (Medicare and Medicaid clients might have 2 insurances)?

☐ Medicaid ☐ Medicare ☐ Cigna ☐ Anthem ☐ Aetna ☐ Optum (United Health)

Other _____

Policy/Member ID #: _____ **Group #:** _____

Phone # of insurance company: _____

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Phone # of insurance company: _____

Are you the policy holder? ☐ Yes ☐ No

If no, name of policy holder and their date of birth: _____

Does an employer pay for your insurance? ☐ Yes ☐ No

If yes, name of employer: _____

Thank you so much for taking the time to fill out this form.
Send completed form to Brooke Davidson, Director of Clinical and Family Services bdavidson@ctjfs.org. We will review this information and get back to you.

Submit

Start Over