1ST CHOICE

CLIENT INTAKE PACKET
1st Choice Mental Health

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1. CLIENT INFORMATION

Full Name: _____
Date of Birth: _____
Phone Number: _____
Email Address: _____
Address:
_____

Emergency Contact Name/Phone: _____

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2. INSURANCE / PAYMENT INFORMATION

Insurance Provider (if applicable): _____
Member ID: _____ Group Number: _____

Responsible Party (if different): _____

Credit Card on File (required for late fees): ☐ Yes ☐ No

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3. REASON FOR SEEKING SERVICES

Please briefly describe what brings you to therapy:

_____
_____
_____

120 N Bell Ave
Shawnee, OK 74801
Phone (405) 296-8538, Fax (405) 296-8539

4. MEDICAL & MENTAL HEALTH HISTORY

Current Medications: _____

Previous Therapy: ☐ Yes ☐ No
If yes, when/why: _____

Any current concerns (check all that apply):
☐ Anxiety ☐ Depression ☐ Trauma ☐ Stress ☐ Sleep
☐ Substance Use ☐ Relationship Issues ☐ Other: _____

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5. TELEHEALTH CONSENT

I have read and agree to the Telehealth Informed Consent Form.
☐ Yes ☐ No

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6. NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge receipt of the Notice of Privacy Practices.
☐ Yes ☐ No

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7. LATE CANCELLATION & NO-SHOW POLICY

I understand and agree to the cancellation policy, including applicable fees.
☐ Yes ☐ No

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8. COMMUNICATION CONSENT

I consent to receive appointment reminders via:
☐ Text ☐ Email ☐ Phone

I understand that electronic communication may have privacy risks.

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9. CLIENT SIGNATURE

Client Name: _____

Signature: _____ Date: _____

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