

VICTORIA ZISKIN MA MFT
MARRIAGE & FAMILY THERAPIST
CA LICENSE #MFC 33277

539 G Street Suite 104
Eureka, CA 95501
Phone: (707) 442-2200

CLIENT INTAKE

(Please Print)

Name: _____

Birth Date: _____ Age: _____ Sex: _____ M F

Address: _____ Marital Status: Single

City/ZIP: _____ Married

Phone: _____ Y__ N__ Work: _____ Separated

Y__ N__ _____ Divorced

Check if okay to leave messages at either/both numbers _____ Widowed

Email address: _____

Check if okay to communicate via email Y____ N____

Occupation: _____

Employer: _____

Name of person responsible for fees if different from above:

Name: _____

Address/City/Zip _____

Insurance Information: Please include copy of both sides of card

Insurance Carrier: _____

Insurance Carrier address: _____

Subscriber (if different): _____ Subscriber DOB: _____

Member ID: _____ Group: _____

By signing below, you agree to allow Precision Billing, Judy Judge and her associates to utilize the above information including service and diagnostic codes to bill your insurance carrier electronically.

The statements made herein are true and correct to the best of my knowledge and belief.

Client's Signature _____ Date _____

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Primary reason(s) for seeking therapy at this time:

Past therapy: Approximate date(s)

Name(s) of prior therapist(s)

Anything you wish to share regarding prior therapy:

How did you hear about the therapist? _____

Were you referred by:

School _____; Doctor _____; Lawyer _____; Criminal Justice _____; Other Agency _____

Have you previously seen a therapist?

Yes _____ No _____ Where? _____

Are you currently taking medication?

Yes _____ No _____ Prescribing MD(s) _____

Please list _____

Please list any/all health issues you are currently (or recently) concerned about and/or being treated for

The statements made herein are true and correct to the best of my knowledge and belief.

Client's Signature

Date