INTAKE INFORMATION

Client Information (Please print)

Name: ____ Date of Birth: __________________________

Street Address: _______________________________________ Social Security #: _______________________

City: ______________________ State/ZIP: _______________ Primary Phone: _________________________

For minor clients

Custodial Parent: _______________________________ Other Parent: _________________________________

Street Address: _________________________________ Street Address: ________________________________

City: ____________________________ State: ________ City: _______________________ State: _______

Phone: _____________________ SSN: ______________ Phone: ______________ SSN: ________________

Source of Referral (if other than self)

Name: _______________________________________ Relationship: _________________________________

Street Address: ________________________________ City: ______________________________ State: _____

Emergency Contact

Contact Name: _______________________________________ Relationship to Client: ___________________

Contact Address: _____________________________________ Contact Phone: _________________________

Primary Medical Provider

Provider Name: ______________________________________ Clinic Name: ___________________________

Clinic Address: ______________________________________ Clinic Phone: __________________________

Medical Information

Current Medication(s)/Dosage: ____

____

Allergies: ____

Other Relevant Medical Information: ____

Insurance Information

Primary Insurance Company: ______________________________ Policy Number: ______________________

Subscriber Name: _______________________________________ **Subscriber DOB:** ___________________

Subscriber Address: _____________________________________ **Subscriber SSN:** ___________________

City: ______________________ **State/ZIP:** _______________ **Primary Phone:** _______________________

Subscriber Employer: ____

Secondary Insurance Company: ___________________________ Policy Number: ______________________

Subscriber Name: _______________________________________ Subscriber DOB: ___________________

Subscriber Address: _____________________________________ Subscriber SSN: ____________________

City: ______________________ State/ZIP: _______________ Primary Phone: _________________________

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