

Client Intake

Patient Information

Date

Full Name

First

MI

Last

Sex

Male Female

Date of Birth

Social Security #

Address

Address Line 1

Address Line 2

City

State

Zip Code

Phone

Email

Employer

Employment Status

Are you currently taking any medications?

Medication List

Current Diagnosis

Primary Insurance Information

Primary Insurance Carrier's Name

Policy Holder Name

First

Last

Relationship to patient

Parent Significant Other Sibling Child Friend

Date of Birth

Social Security #

Group #

Policy / Member ID #

Do you have a second insurance carrier?

Yes No

Emergency Contact Information

Emergency Contact 1

Name

First

Last

Address

Address Line 1

Address Line 2

City

State

Zip Code

Phone

Relationship to patient

Parent Significant Other Sibling Child Friend

Notes