**CLIENT INTAKE FORM**

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|  | **DEMOGRAPHICS** |  |  |
| First Name: | Last Name: | Date of Birth: | Age: |
| Street Address: | Apt #: | City: | State, Zip Code: |
| Primary Phone #: H / C | Secondary Phone #: H / C | Email Address: | Preferred method of contact?* Call
* Text
* Email
 |
| Sex:* Female
* Male
* Prefer not to say
 | Height:Weight: | Relationship Status:* Single
* Married
* Divorced
* Widowed
* Domestic Partner
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|  | **EMERGENCY CONTACT**  | **& HEALTH CARE PROXY** |  |
| Emergency Contact 1: | Relationship: | Phone #:  | Address: |
| Emergency Contact 2: | Relationship: | Phone #: | Address: |
| Health care proxy:  Same as E1   /   Same as E2  | Relationship, contact info:  Same as E1   /   Same as E2  | Advanced Directive:  Y   /   N  Full Code                     DNR/DNI  | Location of AD:  Request info on AD:  Y   /   N  |
| Patient Name: |  |  |  |

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| **PHYSICIAN/** | **REQUEST FOR SERVICES/** | **INSURANCE INFO** |  |
| Referring physician:  | NPI:    | Practice name:  | Phone/Fax:  |
| Current request for Services:    PT                  Diag          OT                  Diag    SLP                 Diag   | New   /   Returning client?   Therapy this year?     Y   /   N      Chiropractic?              Y   /   N   | Prior dates of service during current benefit year?  When:    When:  | Location of prior service during current benefit year?   Where:   Where:  |
| Insurance 1:  | Insurance 2:  | Insurance 3:  | Insurance 4:  |