

Initial Consultation Intake

Date:	Time:	Location: Office	Home	Phone	Other
Client:		Case Opened:			
Disability:		Case No:			
DOB:		Case Closed:			
SSN:		P/E:			
LG:		P/E:			
Relationship:		Address:			
Referral/ WS:					

Preliminary Information:	Preliminary Information:
SSI/ SSA/ SSDI:	Guardians/ Conservators:
Medi-Cal/ Medicare:	Previously Married:
Regional Center Services:	Ex-Spouse Involved:
IHSS Services:	Grandparents Living:
Respite:	Other Children:
Representative Payee:	Retired Military/ Other:
Child Support/ Adoption Subsidy:	State/ Federal Employee:
Client Assets:	Wills/ Family Trust:
Client Liabilities:	Special Needs Trust:
UGMA/ UTMA/ 529/ CAL ABLE:	Powers of Attorney:
Legal Settlement:	Letter of Intent:
Client Employed:	Planning Approved/ Fee:

Notes: _____
