AMANA HEALTHCARE SERVICES, LLC

CLIENT INTAKE FORM

Date:

Name		DOB	Gender	SSN
Address			Marital Status	Race
Ethnicity	Medicaid number	Primary language	Interpreter needed?	Contact number
Alternate contact #	Parent/Guardian Name & Relationship		Client School / Employer	
Medical history				

Current health needs	List any current medication(s)?
Known allergies? Y ( ) No ( )	Are you currently receiving services from another agency? Y ( ) N ( )
Have you previously received mental/behavioral health services? Y ( ) N ( )	If yes, please provide reason for the service, dates and service provider name.
Name of primary care Physician & contact number	
Referral source and contact number	Eligible for service? Y ( ) N ( ). If No, list reason
Community Referral source and date	What date and Time would you like an appointment?

AHS Staff:

20723 Banner Meadow In
Cypress, TX 77433

281-836-3090

info@amanahealthc.com