Client Intake Form

Date: _____

Name: _____ Sex: o Male o Female

Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone #: _____ Evening Phone #: _____

Email:_____

Driver's License #: _____Date of Birth: _____ Occupation: _____

Employer: _____

Employer's Address: _____

Marital status: o Single o Married

Children's Names and Ages: _____

Name of Spouse/Significant Other: _____

Preferred Appointment Day and Time: _____

Insurance Carrier: _____ Policy #:

ID #: _____ Group #: _____ Claim #: _____

Adjuster's Name: _____

Adjuster's Address: _____

City: _____ State: _____ Zip: _____

Telephone #: _____ Extension: _____

Time and Date of Insurance Verification: _____

Primary Health Care Provider: _____

Provider's Address: _____

City: _____ State: _____ Zip: _____

Telephone #: _____ Extension: _____

Permission to Consult with Primary Provider? o No o Yes _____(please initial if yes)

In Case of Emergency, Please Notify:

Name: _____ Telephone #: _____

Relationship: _____