



CLIENT INTAKE

Today's Date: _____

CLIENT INFORMATION

Name: _____ Date of Birth: _____

Pronouns _____ Legal Gender (for Insurance purposes): M F Other N/A

Address: _____

City, State, Zip: _____

Phone Numbers: (H) _____ (W) _____ (C) _____

Which number is best to reach you? _____ Can a phone message be left? Y N Text? Y N

Email Address (thereby giving permission to be contacted via email): _____

Financially Responsible Person: _____ Relationship to Client: _____

Payment Type: _____ Private Pay

INSURANCE INFORMATION (if applicable)

Name of Policyholder: _____ Date of Birth: _____

Policyholder's SS#: _____

Employer: _____ Policyholders Phone #: _____

Insurance Company: _____ Insurance Phone #: _____

Policy #: _____ Group # (if applicable): _____

Number of authorized visits: _____ Authorization # (if applicable): _____

CO-Pay Amount: \$ _____

MEDICAL INFORMATION

Are you currently being treated by a physician(s)? If so, for what? _____

Physician(s) Name: _____

Current medications, if any: _____

FAMILY & EMERGENCY INFORMATION

Whom can I call in case of emergency? _____ Phone # _____

Relationship _____

Please list any significant family members or other people that may be important to your therapy (names and relationship): _____
