

Case Management Intake Form

Patient Information:

- Full Name:
- Date of Birth:
- Gender:
- Address:
- Phone Number:
- Email:

Emergency Contact:

- Name:
- Relationship:
- Phone Number:

Medical History:

- Primary Care Physician:
- Major Illnesses/Conditions:
- Current Medications:
- Allergies:

Current Health Status:

- Reason for Seeking Care:
- Symptoms/Concerns:
- Previous Treatments:
- Current Lifestyle Habits:

Insurance Information:

- Insurance Provider:
- Policy Number:
- Group Number:

Goals and Expectations:

- **Patient Health Goals:**

- **Expectations from Case Management:**

- **Preferred Communication Style:**

Additional Comments: