Client Intake Form

Client Information			
First Name	Last Name	Preferred Name	Patient Identifier (If known)
Gender	Preferred Pronouns	Date of Birth	Marital Status

Address	City	State	Zip Code
Email	Preferred Phone Number		

Emergency Contact		
Full Name	Relationship	
Home Phone	Cell Phone	Work phone
Full Name	Relationship	
Home Phone	Cell Phone	Work phone

Insurance Information		
Insurance Carrier	Insurance Plan	Contact Number
Policy Number	Group Number	Social Security Number

Referrals and Adjunctive Care		
Are you currently under medical care? ☐ Yes ☐ No For? _____		
Primary Care Physician	Address	Contact Number

Health Concerns/Symptoms
Describe your main concerns
When did your chief complaint or illness begin?
What are your goals for today's visit and for your long-term health?