Client Intake Form

Client Information												
First Name	Last Name				Preferred Name				Patient Identifier (If known)			
Gender	Preferred Pronouns				Date of Birth M				Marit	Marital Status		
Address						City		State			Zip Code	
Email					Preferred Phone Number							
Emergency Contact												
Full Name						Relationship						
Home Phone Cell I					Work phone							
The the the the						110111 \$110110						
Full Name					Relationship							
Home Phone			Cell Phone			Work pho			none			
Health Concerns, Symptoms, and Medical Conditions												
Are you currently under medical care? If yes, for what?												
☐ Yes ☐ No												
What are the medications you're currently taking?					ou been diagnosed with other medical conditions?							
☐ Yes					☐ No							
If yes, please list them down.												
Describe your current main concerns below:					When did your chief complaint or illness begin?							
What are your goals for today's visi	t and your long	g-term	health?	?								
Primary Care Physician: Address:									Con	Contact Number:		
Insurance Information												
Insurance Carrier			Insurance Plan			Contact Nur			nber			
Policy Number			Group Number			Social Secu			rity Number			
All the answers to the above questions are answered accurately to the best of my knowledge. I understand that inaccurate information can harm my (or the patient's) health.												
Parent/Guardian's Name (if applicable):					Relationship to Patient (if applicable):							
Signature of Client, Parent, or Guardian:			Signature of the F			Primary Care Physician:			ı	Date:		