New 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	Contact Number
Full Name	Relationship	Contact Number

Health and Medical Information		
Primary Care Physician	Address	Contact Number
Please list any medical conditions		
Please list any current medication		

Insurance Information (If Applicable)		
Insurance Carrier	Insurance Plan	Contact Number
Policy Number	Group Number	Social Security Number

Employment Status

◯ Employed ◯ Self Employed ◯ Unemployed ◯ Other _____

Occupation	Industry	Company Name

Company Address	City	State	Zip Code

All the answers given to the above questions are answered accurately to the best of my knowledge. I understand that any inaccurate information can be dangerous to my (or patient's) health.

Parent or Guardian Name (If Applicable)	Relationship to Patient (If Applicable)
Signature of Client, Parent or Guardian	Date