# Client Intake Form

**ALL INFORMATION MUST BE FILLED IN COMPLETELY.**

Date:_____

**Personal Information**

**Patient Last Name: _____First: _____Middle Initial: _____**
**Name preferred to be called:_____**
**DOB:_____ Sex:_____ SSN:_____**
**Street Address:_____ City:_____ State:_____ Zip:_____**
**Home Phone: (____)_____ Cell Phone: (_____)_____ Work Phone: (_____)_____**
**Is it okay to call you at work? (_____ Yes) ( _____ No)**
**Marital Status: (_____ Single) ( _____ Married) (_____ Widowed) (_____ Divorced) ( _____ Separated)**
**If we may contact you by email, please place your email here:_____**
**Whom may we thank for referring you?_____**

**Emergency Contacts:**

1. **Name:_____ Home Phone: (___)_____ Work Phone: (___)_____**
   **Relationship_____**
2. **Name:_____ Home Phone: (___)_____ Work Phone: (___)_____**
   **Relationship_____**

**Family Information:**

**Spouse:_____ Cell Phone: (___)_____ Work Phone: (___)_____**
**Person who will always know your whereabouts:_____**

**Person of Financial Responsibility:**

**Full Name:_____**
**Relationship:_____**
**Street Address:_____ City:_____ State:____ Zip:_____**
**Home Phone: (____)_____ Cell Phone: (_____)_____Work Phone: (_____)_____**
**SSN:_____ DOB: _____**

**Primary Insurance Information:**

**Primary Insurance Company:_____**
**Policy ID Number:_____ Group Number: _____**
**Employer:_____**
**Street Address:_____ City:_____ State:_____ Zip:_____**
**Primary Card Holder Name:_____**
**Relationship to Client:_____**
**DOB:_____ Insured SSN:_____**

**Secondary Insurance Information:**

**Primary Insurance Company:_____**
**Policy ID Number:_____ Group Number: _____**
**Employer:_____**
**Street Address:_____ City:_____ State:_____ Zip:_____**
**Primary Card Holder Name:_____**
**Relationship to Client:_____**
**DOB:_____ Insured SSN:_____**