

CLIENT INTAKE FORM

Client Name: Last _____ First _____ Mdl. _____

Address _____ City _____ State _____ Zip _____

Home Phone (____) ____-____ Pager/Cell (____) ____-____ Work (____) ____-____

Employer _____

Ok to call? work home cell/pager

Please circle any that apply

Ok to leave message? work home cell/pager

Please circle any that apply

Marital Status ____ (S - Single, M - Married, P - Partnered, W - Widowed, D - Divorced, SP - Separated)

Sex ____ Social Security No. ____-____-____ Date of Birth ____/____/____

Check here if you **do not** want the office to contact you **via mailings**. _____

However, it may become necessary to mail bills.

EMERGENCY CONTACT: _____ Phone: _____

Relationship to client: (i.e., wife, husband, friend, etc.) _____

Ok to call? work home cell/pager

Please circle one

Ok to leave message? work home cell/pager

Please circle one

RESPONSIBLE PARTY INFORMATION: (Parent or guardian if client is a minor)

Name Last _____ First _____ Mdl. _____

Address _____ City _____ State _____ Zip _____

Home Phone (____) ____-____ Pager/Cell (____) ____-____ Work (____) ____-____

Ok to call? work home cell/pager

Please circle one any that apply

Ok to leave message? work home cell/pager

Please circle one any that apply

Relationship to **client** ____ (S-Self, P-Spouse, C-Child, O-Other)

REFERRAL INFORMATION:

Name of the individual/organization who referred you to this practice/ therapist _____

Phone (____) ____-____ Ok to contact? _____

I am aware this office is HIPAA compliant and have **received/refused (circle one)** a copy of the Practice Privacy Statement _____

My signature indicates that I am in agreement with providing the above information.

Client/Guardian/or Legal Equivalent

Date