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