Client Intake

Date: //

Client Name: DOB://

Parent/Guardian Name (if under 18 years old):

Street Address (include apt/unit # if applicable):

City:  State: Zip Code:

Cell Phone: ()- Work Phone: ()-

Home Phone (if available): ()-

Email address:

Emergency Contact Name:

Relationship to Client: Phone:()-

Name of Party Responsible for Payment:

Phone (if someone other than yourself): ()-

Address (if someone other than yourself):

City: State: Zip Code:

Referral Source:

Previous Treatment/Therapy:

Do you have a physical or medical disability? (Check one): [ ] YES [ ] NO

If YES, please describe:

(Complete if applicable)

Attorney Name:

Phone: ()- Fax: ()-

Address:

**COORDINATION OF TREAMENT:** It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization. If you prefer to decline consent no information will be shared. (Check one)

[ ] You may inform my physician(s) [ ] I decline consent to inform my physician(s)

Physician Name:

Name of Clinic:

Adress:

Phone: ()- Fax: ()-

Date of last physical exam: //

Signature:      Date: //