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: //