

Client Intake Form

Client Information				
First Name	Last Name	Preferred Name	Patient Identifier (If known)	
Gender	Preferred Pronouns	Date of Birth	Marital Status	
Address		City	State	Zip Code
Email		Preferred Phone Number		
Emergency Contact				
Full Name		Relationship		
Home Phone	Cell Phone		Work phone	
Full Name		Relationship		
Home Phone	Cell Phone		Work phone	
Health Concerns, Symptoms, and Medical Conditions				
Are you currently under medical care?		If yes, for what?		
☐ Yes ☐ No				
What are the medications you're currently taking?		Have you been diagnosed with other medical conditions?		
		☐ Yes ☐ No		
If yes, please list them down.				
Describe your current main concerns below:		When did your chief complaint or illness begin?		
What are your goals for today's visit and your long-term health?				
Primary Care Physician:	Address:		Contact Number:	
Insurance Information				
Insurance Carrier	Insurance Plan		Contact Number	
Policy Number	Group Number		Social Security Number	
All the answers to the above questions are answered accurately to the best of my knowledge. I understand that inaccurate information can harm my (or the patient's) health.				
Parent/Guardian's Name (if applicable):		Relationship to Patient (if applicable):		
Signature of Client, Parent, or Guardian:		Signature of the Primary Care Physician:		Date: