

# Client Intake Form

Date: \_\_\_\_\_  
Name: \_\_\_\_\_ Sex:  Male  Female  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Daytime Phone #: \_\_\_\_\_ Evening Phone #: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Email: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
Marital status:  Single  Married

## Insurance Information

Insurance Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_  
ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Claim #: \_\_\_\_\_  
Adjuster's Name: \_\_\_\_\_  
Adjuster's Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone #: \_\_\_\_\_ Extension: \_\_\_\_\_

## Referral Information

Primary Health Care Provider: \_\_\_\_\_  
Provider's Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone #: \_\_\_\_\_ Extension: \_\_\_\_\_  
Permission to Consult with Primary Provider?  No  Yes \_\_\_\_\_ (please initial if yes)

## Emergency Contact

Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
Relationship: \_\_\_\_\_

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