CLIENT INTAKE SHEET

Client's Name Birthdate Age Gender Marital Status

Client's Name Birthdate Age Gender Marital Status

Client's Address City, State Zip Code

Employer's Name Occupation Email Address

Home Phone Number Cell Phone Number Best Number to Call

How did you hear about us? Type of Therapy Seeking

PRIMARY INSURANCE CARRIER

Policy Holder's Name Date of Birth Relationship to Insured

Marital Status Employer Name Occupation

Insurance Company Name & Address (City, State, Zip Code) Insurance Phone

Group Name & Number Plan Number ID Number Effective Date

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM OR PAYMENT OF MEDICAL BENEFITS TO PROVIDER FOR SERVICES DESCRIBED.

NAME_____DATE_____