CLIENT INTAKE FORM

Primary Client's Name Birthdate Age Gender Relationship Status

Secondary Client's Name Birthdate Age Gender Relationship Status

Primary Client's Address City, State Zip Code

Primary Employer's Name Occupation

Primary Phone Number Secondary Phone Number

Primary Email Address Secondary Email Address

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.

Primary Client Signature Date