



INTAKE PACKET

Date _____

CLIENT INFORMATION

Client Name _____ Age, _____

Street Address _____ City _____ /State/Zip _____

Home Phone # _____ **May we call or leave a message at this number?** Yes No

Daytime Phone # _____ **May we contact you here?** Yes No

Cell Phone # _____ **May we call or leave a message on this phone?** Yes No

Email _____

Client Date of Birth _____ Social Security # _____ Marital
Status: Married, Single, Other

List Children/Others living with you/the client (Name, Relationship, Age):

If client is minor, or has a Guardian: Name of Guardian or
Parent _____ Phone _____

Date of Birth _____ Email _____

Address _____

Spouse/Significant Other Name: _____

Work Phone _____ Age: _____

Date of Birth: _____

Primary Care Physician _____

Phone: _____ Fax: _____

Emergency Contact Name _____ **Phone #:** _____
Address _____

Are you employed? Yes _____ No _____ Employer :