INTAKE INFORMATION

Date_____

Patient Name_____ Patient Date of Birth_____
Patient Social Security Number_____ Referred by_____
Patient Address _____City_____State_____Zip_____

Phone (hm)_____Wk_____
Cel Ph_____ Email _____

Ok to leave message? (Please circle yes or no) Home: yes no Wk: yes no Cel: yes no email: yes no

Marital Status of patient (circle): single married divorced widowed Ethnicity:

Information about spouse of patient (if married):
Name_____
Date of birth_____

Patient Occupation_____ Place of employment_____
If patient is a student, identify school and grade_____

Parent(s)/Guardian(s) (if patient under age of 18):

Name: _____	Name:_____
Date of birth:_____	Date of birth:_____
Address_____	Address_____
Phone (hm)_____ (Wk)_____	Phone (hm)_____ Wk_____
Cell_____'	Cell_____
Occupation_____	Occupation_____
Place of Employment_____	Place of Employment_____

Family physician_____

If the patient has children, please identify them by name and age:_____
_____

Other children of parents/guardians of patient by name and age (only if patient is minor child): _____
_____

_____

To whom should fee for services be directed? (only if someone other than the patient is responsible)
Name_____ Address_____

Briefly describe the reasons for treatment: