INTAKE SHEET

DATE: _________________

REFERRED BY: _________________

CLIENT NAME: ______________________________

DOB: __________ AGE: _______ SEX: _________ MARITAL STATUS: __________

SOCIAL SECURITY #: ___________________________

PARENT (IF MINOR): ___________________________

ADDRESS: ____

CITY: ___________________ STATE: __________________ ZIP CODE: _______________

HOME PHONE: _______________________

WORK PHONE: _______________________

CELL PHONE: _________________________

EMERGENCY #: _______________________

EMAIL ADDRESS: ________________________________

PRIMARY CARE PHYSICIAN: ______________________PHONE: ___________________