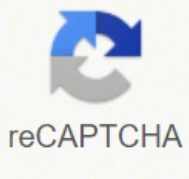




I'm not robot



Open



New Client Intake Form

Personal Information

First Name: _____ Last Name: _____
 Middle Initial: _____
 Date of Birth: _____ Sex: _____
 Home Phone: _____ Mobile Phone: _____
 May we leave a message at this number? Yes No
 May we leave a message at this number? Yes No

Medical Provider Information

Primary Health Care Provider: _____
 Address: _____

Health Information

Primary Health Care Location: _____
 Past Medical History: _____
 Current Medications: _____
 Current Treatments: _____
 Allergies (Food/Drugs/Environment): _____
 Current Exercise Name and Frequency: _____

Do you smoke? Yes No Previously Do drink caffeine? Yes No Previously

Do you have, or have you ever had, any of the following (check all that apply):

<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Low Blood Sugar
<input type="checkbox"/> Abnormal or Bilemia	<input type="checkbox"/> Eye Problems	<input type="checkbox"/> Neurological Disorders
<input type="checkbox"/> Anxiety Disorder	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Panic Attacks
<input type="checkbox"/> Any Psychiatric Disorder	<input type="checkbox"/> Heart Attack or Angina	<input type="checkbox"/> PMS or Hot Flashes
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Murmurs	<input type="checkbox"/> Seizures or Epilepsy
<input type="checkbox"/> Blood Disorders	<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Swollen Ankles
<input type="checkbox"/> Chronic Constipation	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Chronic Fatigue Syndrome	<input type="checkbox"/> High Cholesterol/Triglycerides	
<input type="checkbox"/> Chronic Lung Problems	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Other Serious Health Conditions

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Provider Name, Licenses
 Provider Address, Provider Phone

Intake Form

Demographic Information

First Name: _____
 Middle Initial: _____
 Last Name: _____
 Date of Birth: _____
 Social Security Number (Optional): _____
 Sex: M / F
 Marital Status: _____
 Address: _____
 City: _____
 State: _____
 Zip Code: _____
 Phone Number: _____
 Email Address: _____
 Referring Physician Name (Optional): _____
 Referring Physician Phone Number & NPI (Optional): _____

Insurance Information

Primary Insurance Company: _____
 Subscriber ID # (including letters): _____
 Group Number: _____
 Secondary Insurance Company: _____

COUNSELING INTAKE FORM

Note: This information is confidential.

Demographic Information:

Name: _____ Date: _____
 Date of Birth: _____ Relationship Status: _____
 Age: _____ SSN: _____
 Gender: M / F
 Home/Mobile Phone: _____ Is it ok to leave a message for you at this number? Y / N
 Work Phone: _____ Is it ok to leave a message for you at this number? Y / N
 Email: _____ Is it ok to email you? Y / N
 Mailing Address: _____
 Current Employer: _____ Position Title: _____
 Current Occupational Status: (i.e., F/T, P/T, self-employed, student, returning to work): _____
 Emergency Contact Name & Relationship: _____
 Emergency Contact Phone: _____
 How were you referred? _____ If online, which website? _____

Behavior – circle any of the following behaviors that apply to you:

Overeat	Suicidal attempts	Can't keep a job	Take drugs	Compulsions
Insomnia	Vomiting	Smoke	Take too many risks	Odd behavior
Withdrawal	Lack of motivation	Drink too much	Nervous tics	Eating problems
Work too hard	Procrastination	Sleep disturbance	Crying	Impulsive reactions
Phobic avoidance	Outbursts of temper	Loss of control	Aggressive behavior	Concentration difficulties

Feelings – circle any of the following feelings that apply to you:

Angry	Guilt	Unhappy	Annoyed	Happy	Bored	Sad
Conflicted	Restless	Depressed	Regretful	Lonely	Anxious	Hopeless
Contented	Fearful	Hopeful	Excited	Panicky	Helpless	Optimistic
Energetic	Relaxed	Tense	Envious	Jealous	Others: _____	

Physical – circle any of the following symptoms that apply to you:

Headaches	Stomach trouble	Skin problems	Dizziness	Tics
Dry mouth	Palpitations	Fatigue	Bumping or itchy skin	Muscle spasms
Twitches	Chest pains	Tension	Back pain	Rapid heart beat
Sexual disturbances	Tremors	Unable to relax	Fainting spells	Blackouts
Bowel disturbances	Hear things	Excessive sweating	Tingling	Watery eyes
Visual disturbances	Numbness	Flushes	Hearing problems	Don't like being touched



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