

New Patient Client Intake Form

Client Information

- Full Name: _____
- Preferred Name (if any): _____
- Date of Birth: ____ / ____ / ____
- Address: _____
City: _____ State: _____ ZIP: _____
- Phone Number: _____
- Email Address: _____

Emergency Contact

- Name: _____
- Relationship: _____
- Phone Number: _____

Reason for Seeking Services

Briefly describe the reason for your visit:

Health History

- Current Medications: _____
- Known Allergies: _____
- Prior Medical Diagnoses: _____

Service Preferences

What type of service are you seeking?

General Consultation Ongoing Treatment Other: _____

Consent and Agreement

I agree to provide accurate and truthful information and understand the policies of the practice.

Signature: _____ Date: _____