Adult, Child & Family Services

Client Intake Form

Client Information

Client Name: ___________________________________ DOB: _________________________

Address: _______________________________________ Gender: _______________________

City, State, Zip: _________________________________ Race: _________________________

SSN: ____

Home Phone: ________________ Cell Phone: __________________ Okay to leave a message: Yes/ No

Email: ____ Okay to email: Yes/ No

Employer: ___________________________________ Phone: ________________________

Address: _____________________________________

City, State, Zip: ______________________________

Name of Spouse/ Guardian: ____________________________ Relationship: _______________________

Phone: _______________________________________

Emergency Contact: __________________________________ Relationship: _______________________

Phone: _______________________________________

Insurance Information

Insurance Company: ________________________ Policy ID: __________________________

Policy Holder Name: ________________________ Group Number: _____________________

Coordination of Care-Referral Source

Name of Provider: __________________________ Business Name: __________________

Address: ___________________________________ Phone: ____________________________

City, State, Zip: ____________________________

Appointment

Brief reason for the appointment: