|  |  |  |  |
| --- | --- | --- | --- |
|  | Client Intake Form |  |  |
|  |  |  |
|  |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Client Name |  |  |
| Client Information |
|  |
|  |  |  |  |  |
| Home Phone | Cell Phone | DOB |
|  |
| Address |
|  |  |  |  |  |
| City |  | State. |  | ZIP Code |
|  |
| Condition being treated |
|  |  |  |
| Provider that DiagnosedSign: |  | Provider Phone Number |
| Permission to treat and bill insurance |  | Date: |

 |  |