INITIAL CONTACT INTAKE SHEET

DATE OF 1ST APPT: _____ DATE OF INCIDENT: _____ TODAY'S DATE: _____

CLIENT NAME: _____ PARENT'S NAME: _____

CLIENT ADDRESS: _____

HOME PHONE: (___) _____ WORK PHONE: (___) _____ DATE OF BIRTH: _____

LEVEL OF EDUCATION: _____ MILITARY EXPERIENCE: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY/RELATIONSHIP: _____ PHONE: (___) _____

EMPLOYER NAME: _____ EMPLOYER ADDRESS: _____

SOCIAL SECURITY NUMBER: _____ REFERRAL SOURCE: _____

INSURANCE INFORMATION

INSURANCE COMPANY (responsible party): _____ ADJUSTER/CONTACT PERSON: _____

CLAIMS ADDRESS: _____

CLAIMS PHONE NUMBER: _____ FAX #: _____

POLICY/GROUP/CLAIM NUMBER: _____ SUBSCRIBER & NUMBER: _____

ATTORNEY INFORMATION

ATTORNEY NAME: _____ PHONE: _____

ADDRESS: _____ FAX #: _____

HISTORY

HISTORY OF INJURY: _____

_____

LOSS OF CONSCIOUSNESS: _____

PRESENTING PROBLEMS: _____

_____

_____

_____

PREVIOUS THERAPIES/HEALTH CARE PROVIDERS: _____

_____

_____

PRIMARY CARE PHYSICIAN: _____

PREVIOUS PSYCHIATRIC CONTACT: _____

_____

INTAKE COMPLETED BY: _____

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