CLIENT INTAKE FORM

Date:_____

Name of Patient:
DOB:_____Age_____
Phone #:
Address_____.
City _____State_____Zip_____
Emergency Contact Number (_____) Name/Relationship _____

Hospital/Medical Center:_____
Date hospitalized_____
Dx_____
Surgery?_____
Contact/Case Manager:_____
Phone #:_____
Fax #:_____

Physician/Provider Name:_____
Specialty_____
Phone #:_____
Contact:_____
Fax #:_____
Last visit_____

Physician/Provider Name:_____
Specialty_____
Phone #:_____
Contact:_____
Fax #:_____
Last visit_____

Other provider Name_____
Specialty_____
Phone #_____
Contact_____
Fax_____
Last visit_____

Type of Service received/ needed: □ In-Patient □ Out-Patient □Home Health □ DME □ Infusion □ PT □ OT □ SP Pain Management Long Term Care
DX:_____
ICD 9 Codes: _____
Procedure/CPT Codes:_____

Did this injury or illness occur during the course of employment? Yes No
.
Records Requested from _____ Records Received _____
Records Requested from _____ Records Received _____
Records Requested from _____ Records Received _____

PRESENTING PROBLEM/CASE MANAGEMENT NEED: (type of illness, injury, disability and complaint with whom…physician, hospital, etc?)

MENTAL HEALTH

Receiving mental health counseling? Yes No
Clinician:_____
Phone:_____
Dx_____
Has client ever **received** mental health counseling? Yes No
When_____ For how long? _____
Ever **hospitalized** for a psychiatric condition? Yes No
Most recent date:_____ Where?_____
_____

PRIMARY INSURANCE

Indicate all that apply:
Medicare #_____
Medicaid: Number with Sequence # _____
Private Insurance:_____ID_____
Phone:_____
Effective date:_____

SECONDARY INSURANCE

Name_____
ID #_____
Phone_____
Effective Date of Secondary Insurance: _____

MEDICATIONS: (Name, dosage, etc.)

OTHER NEEDS:

SUMMARY NOTES: