



# WINNING YOUR WELLNESS BACK

P.O. Box 634; MESA, AZ 85211

REBECCA L.S. WINN NLMT, NCBTMB

## CLIENT INTAKE FORM

DATE: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ SEX: \_\_\_ MALE \_\_\_ FEMALE

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOUSE #: ( ) DAY \_\_\_ NIGHT \_\_\_ WORK #: ( ) DAY \_\_\_ NIGHT \_\_\_

MOBILE #: ( ) DAY \_\_\_ NIGHT \_\_\_ OTHER #: ( ) DAY \_\_\_ NIGHT \_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ DRIVER LICENSE #: \_\_\_\_\_

MARITAL STATUS: \_\_\_ SINGLE \_\_\_ MARRIED \_\_\_ DIVORCED \_\_\_ WIDOWED

SPOUSE 'S NAME: \_\_\_\_\_

CHILDREN 'S NAMES/ AGES: \_\_\_\_\_

PREFERRED APPOINTMENT DAY/TIME: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

PRIMARY CARE PROVIDER: \_\_\_\_\_

PROVIDER 'S ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ EXTENSION: \_\_\_\_\_

PERMISSION TO CONSULT WITH PRIMARIY PROVIDER? \_\_\_ NO \_\_\_ YES (INITIAL IF YES): \_\_\_\_\_

INSURANCE CARRIER: \_\_\_\_\_ POLICY #: \_\_\_\_\_

ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_ CLAIM #: \_\_\_\_\_

ADJUSTER 'S NAME: \_\_\_\_\_

ADJUSTER 'S ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ EXTENSION: \_\_\_\_\_

TIME AND DATE OF INSURANCE VERIFICATION: \_\_\_\_\_

### IN CASE OF EMERGENCY PLEASE NOTIFY:

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_