# 

# 

## 71 Spit Brook Road, Suite 310, Nashua, NH 03060 603.882.3786

# Client intake form

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  | | --- | --- | | Today’s Date: | Referral Source: |  Client INFORMATION  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | First Name: | | | | Last Name: | | | | | Street Address: | | | | | City: | State: | Zip: | | | Zip code: | | Home Phone #: | | | Cell Phone #: | | | Appointment Reminder:  Text Email None | | | DOB: | Age: | Email Address: | | | | | | |  | |  Emergency contact  |  |  |  |  | | --- | --- | --- | --- | | Name: | Phone #: | Relationship: | Middle name: |  Medical INFORMATION  |  |  | | --- | --- | | Primary Care Doctor: | Phone #: | | Psychiatrist: | Phone #: |  medications  |  |  |  |  | | --- | --- | --- | --- | | Name: | Dosage: | Date Started: | | |  |  |  | | |  |  |  | | |  |  |  | | |  |  |  | | | **Please list any allergies:** | | | | | Insurance INFORMATION | | | | | |  |  |  | | --- | --- | --- | | Insurance Plan: | ID #: | Group #: | | EAP Authorization #: | Subscriber: | Subscriber DOB: | | Copayment: | Subscribers Employer: | Private Pay: | | The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Erin K. Crail. I understand that I am financially responsible for any balance. I also authorized Erin K. Crail to release any information required to process my claims to my insurance company. | | | | | | | | **Client Signature:** | | | Date: | |