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

# Client intake form

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|  |  |
| --- | --- |
| 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. |

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|  **Client Signature:** |  Date: |

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