

Emotional Change
Patient Intake Form

Patient First Name:

Patient Last Name:

Patient Address:

City

State

Zip code:

Patient Date of Birth:

Employed/Student?:

Marital status:

Phone Number (Best for reaching patient):

Is it okay to text?: YES: NO:

Availability (days, nights, Mondays only, etc.):

Location:

Presenting Issue:

Insurance:

Insurance ID Number:

Insurance group number:

Insurance Phone Number (located on back of the card):

Is the policy holder same as patient? : YES: NO:

Policy Holders Name (if different):

Policy Holders Date of Birth (if different):