TRANSFORMATIVE LIFE CENTER, LLC.

Client Intake Form

Client Information:

NAME: Last_____ First _____ Middle _____

ADDRESS: _____City _____State _____ Zip _____

HOME PHONE: _____ WORK PHONE:_____
CELL PHONE: _____ Email Address _____
DATE OF BIRTH: _____ Social Security Number: _____-_____-_____ SEX: _____
MARITAL STATUS: _____ (S-Single M-Married W- Widowed D- Divorced P-Separated
Employer: _____ Occupation:_____
(IF MINOR): MOTHER: _____ FATHER: _____

SCHOOL: _____ GRADE: _____
LEGAL CUSTODY: MOTHER FATHER JOINT OTHER (CIRCLE ONE)
Name of Legal Guardian (If Applicable): _____

Who do we call in the event of an emergency? _____ Telephone#_____

If you are not financially responsible for all professional services rendered to you at the office please inform us what party is responsible by filling in the next section:

Responsible Party: (list either the name of the organization of person who is financially responsible for your account)

Name of Organization: _____
Individual's Name: Last _____ First _____ Middle _____
SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____
ADDRESS: _____ City _____ State _____ Zip _____
HOME PHONE: _____ WORK PHONE:_____

Were your referred to our office? ☐no ☐yes **If yes, by whom?** _____

Primary Care Physician / Medical Information: Do we have permission to contact your physician? ☐no ☐yes

Name of Physician: Dr. _____ Telephone #: _____
Clients that provide us with permission to contact their primary care physician will have a brief letter sent to their doctor indicating that contact has been made at our office. Diagnosis information may also be released to the physician. If we have permission to contact your doctor, please sign below indicating you give us permission to inform your doctor about the services you are receiving. **Client signature**: _____ Date: _____
Witness to Signature: _____

Medications you are taking: _____
Medical Conditions you are being treated for currently:_____

Insurance Policy Holder Information: Policy Holder Name: _____
Address: _____ City_____ State ____ Zip_____
Relationship to Patient: _____ Telephone # _____
SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____ SEX: _____
EMPLOYER: _____
NAME OF INSURANCE CARRIER: _____
ID#:_____ GROUP#:_____
CLAIMS ADDRESS: _____
BENEFITS PHONE #: _____

Please provide a copy of your insurance card and necessary identification