**CPWithus Consulting** **Client Intake Form**

 Today’s Date

**Client Profile**

Name Age Birth Date

Address Gender Marital Status

City State Zip

Home Phone

Work Phone

Cell Phone

Email

**Parent(s)/Guardians(s)**

Name Marital Status

Address City State Zip

Home Phone

Work Phone

Cell Phone

Email

Name Marital Status

Address City State Zip

Home Phone

Work Phone

Cell Phone

Email

Client Sibling Age

Client Sibling Age

Client Sibling Age

Client Sibling Age

**Responsible Party** (if same as client skip to next section)

Name Gender: M F Birth Date

Address City State Zip

Home Phone

Work Phone

Cell Phone

Relationship to Client Social Security No

**Emergency Contact** (not residing with client)

Name

Relationship to Client

Home Phone

Work Phone

Cell Phone

**Client Disability and Medical Info**

Primary Disability Secondary Disability

Please describe client disability(s)

**Disability Support**

Primary care Physician Name Phone

**Specialist Support**

Physical Therapist Name Phone

Orthopedist Name Phone

Neurologist Name Phone

Chiropractor Name Phone

Fitness Trainer Name Phone

Psychologist Name Phone

**Other Specialist Support** (please provide area of specialty; name; phone)

**How did you hear about CPWithus?**

**Please briefly explain the reason for contacting CPWithus?**

I hereby assign payment of authorized benefits to which I am entitled to be made directly to Peter Turner for services he provides to me. I authorize any holder of medical information about me to release any information needed to determine if these benefits are payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am responsible for all charges not paid for by insurance. I hereby authorize Peter Turner to release all information necessary to secure payment.

Signature.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_