WINNING AT HOME

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winningathome.com

Adult Intake Form

CONFIDENTIAL

PATIENT INFORMATION

Name: Date of Birth: Sex: M F

Address: City: ZIP:

Home Phone: Cell Phone:

Email: Social Security #:

Religious Affiliation:

Employer: Work Phone:

Work Address: City: ZIP:

FAMILY INFORMATION

○ Single ○ Married ○ Separated ○ Divorced ○ Widowed ○ Living Together

Name of spouse/significant other:

CHILDREN

Name	Age	School/Grade	Biological/Adopted
1.			
2.			
3.			
4.			

Name of anyone else living in the home:

Form Continues on back side

MEDICAL HISTORY

Physician's name: **Date of last physical:**

Are you currently being treated for any medical conditions? YES NO

If yes, please explain:

Are you currently taking any medications? YES NO

If yes, please list:

Please list any allergies:

Have you received previous counseling? YES NO

If yes, by whom? **Date/Year:**

Please briefly state why you are currently seeking counseling:

REFERRAL INFORMATION

Referred by: **Address:**

I would like to send a note of appreciation to the person who referred you for supporting our ministry.
Please sign for your permission.

Signed: **Date:**

COMMUNICATION AUTHORIZATION

I authorize Winning At Home Family Wellness Center to use the email and mobile number listed above to send changes and/or confirmations to my appointment schedule via text message or voice mail.

Signed: **Date:**

EMERGENCY CONTACT INFORMATION

Name: **Phone Number:**

Relationship to Client: