Confident Living Home Therapy
Client Intake Information

Client Name: _____ Date:_____
DOB:_____ Gender Identity: _____
Address: _____
City:_____ State: _____ Zip:_____
E-mail Address: _____
Cell Phone: _____ Other Phone:_____

If mailing or billing address is different than physical address, please list here:
_____

Referred By: _____
Primary Care Physician:_____
Name of Practice:_____
Address:_____
Phone: _____ Fax: _____

If client has a legal guardian, please complete the following:
Name: _____Relationship to client: _____
Address (if different from above):_____
Phone (if different from above): _____

Emergency Contact:
Name:_____Phone:_____
Relationship to Client:_____
Do you give permission to release pertinent medical information to this person?
_____Yes or _____No

Insurance and Payment Information:

Person responsible for payment(s):_____

Primary Insurance:_____

Primary Insured Name: _____

Secondary Insurance Name:_____

please be prepared to provide insurance cards for copies

If my insurance policy/plan limits the number of therapy visits allowed, I understand that I am responsible for keeping track of the number of used or remaining visits. If the client is seen beyond the approved number of visits, I understand that I am responsible for all charges that exceed the allowed number of visits approved by my insurance company.

Initials_____ Date _____

Therapy Questionnaire

Please list all current and past medical conditions (ex. Stroke, diabetes, etc:)

_____

_____

_____

_____

Please list all surgeries pertinent to your visit: _____

_____

_____

_____

Please list any medications you are *currently* taking:

_____

_____

_____

_____

Are you allergic to any medications? Y or N

If yes, please list reactions: _____

Are you allergic to anything other than medications? Y or N

If yes, please list reactions: _____

How did you find out about us? _____

What is your major concern that led you to seek help? _____

How long have you had these concerns? _____

Occupation: _____

Please check areas of your life affected by these issues/concerns:

_____Home _____School _____Work _____Social _____Church

_____Public Places _____Other

With whom do you currently live? _____

Do you currently have caregiver(s) in the home?_____

If yes, how frequently? _____

Have you had any therapies in the past? Y or N

If yes, please list dates and for which condition(s).

Physical Therapy: _____

Occupational Therapy: _____

Speech Therapy: _____

Please include anything else you think may be helpful for us to know about:

_____

_____

_____

8906-F West Broad Street, Richmond VA 23294 | P: 804-351-5824 F: 844-600-2797 |
www.confidentlivinghome.com