

Group _____

Intake Form for Phase I: Getting Started

Date _____ Social Security No. _____

Name _____ D.O.B. _____ Age _____

Address _____

City _____ State _____ Zip _____

Phone Numbers: Home _____ Work _____

Occupation _____ Highest Level of Education _____

Emergency Contact _____ Phone Number(s) _____

Address _____

City _____ State _____ Zip _____

Relationship _____

Family Physician _____ Phone Number _____

Referred by _____

Address _____

City _____ State _____ Zip _____

Will this person need to be contacted? _____

May we send information about this program? _____

With whom are you now living? List people and relationship(s): _____

Please list medications: _____
