PHOENIX THRIVING, PLLC

Date:_____

CLIENT INTAKE INFORMATION

Name:_____ DOB:_____

Birth Assigned Gender: _____ Current Gender Identity:_____

Your Pronouns: _____ Relationship status: _____

Children: Y N If yes, how many: _____

Address: _____

City/St/Zip:_____

Home/Cell #: _____ E-mail: _____

School/Employer: _____

Occupation: _____ How Long? _____

Please acknowledge whether you utilize the following types of care and, if so, list the names of providers with whom you currently work:

Physician (MD or DO) Y N _____

Homeopath/Naturopath Y N _____

Chiropractor Y N _____

Acupuncturist Y N _____

Other Healing Arts Y N _____

Current/ongoing Medical Conditions:_____

_____

_____

What brings you here today? _____

_____

_____

_____

Name Date

Current Medications/Herbs/Supplements:

Rx	Reason for taking	Dosage	Date prescribed

_____

_____

_____

_____

_____

_____

Previous Counseling and/or Mental Health Hospitalizations:

Dates/Location	Reason	Outcome – (i.e. issue resolved?)

_____

_____

_____

_____

_____

_____

Emergency Contact Information

Name: _____ Phone: _____

Relationship: _____