**ReBalance Therapy**

Mind. Body. Soul.

**Counseling Intake Form**

*\*This Form is Completely Confidential*

Patient First Name:

Patient Middle Name:

Patient Last Name:

Patient Preferred Name:

Home Phone:

Cell Phone:

Social Security Number:

Sex (please circle): Male Female Other

Gender Identity:

Preferred Pronoun:

Marital Status:

Age:

Date of Birth:

Race:

Ethnicity:

Email Address:

Address

City:

State:

Zip:

Emergency Contact First Name:

Emergency Contact Last Name:

Emergency Contact phone:

Emergency Contact Relationship:

Do you have insurance (please circle): Yes No

Do you have secondary insurance (please circle): Yes No

Patient/Client First Name:

Patient/Client Last Name:

Patient/Client Signature:

Date: