genesis therapy center
Discovery…Recovery…Growth

Identifying Information		Today's Date:

ADULT CLIENT INTAKE

Name:	I.D. #	Date of Birth: Sex:
Home Street Address:	SSN:	On Disability?
City, State, Zip	Employer/School:	Certification #: Precert #:
May we add your email address to our mailing list? Yes ( ) No ( ) Email:	Telephone: Home Work Cell	Release of Information Signed? Yes ( ) No ( )

INSURED INFORMATION

Name:	SSN:	Relationship to Client:
Address:	Date of Birth:	
City, State, Zip		
Name of Insurance Co.:	Group #:	I.D. #:
Demographics:	_____ African-American _____ Caucasian	_____ Hispanic _____ Other

EMERGENCY INFORMATION

In the event of an emergency, who would we contact on your behalf?

Name:	Telephone Number:	Relationship to you (if any):
Address: City	State	Zip

FAMILY INFORMATION

Please list the following information for those you live with:

Name	Relationship to you	Age

How were you referred to The Genesis Therapy Center? _____

_____