**INTAKE ASSESSMENT FORM – CARE PLAN**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name | | | | | Date |
| Address | | | Phone  E-mail | | |
| Age/Date of Birth | | Occupation | | | |
| Social Situation (Marital Status, Support, Pets, Family Situation) | | | | | |
| Health Care Professionals | | | | | |
| Reason for Visit | | | | | |
| Medical History | | | | | |
| Medications/Supplements | | | | Allergies | |
| Stress & Areas of Concern | | | | | |
| Relaxation/Self-Care | | | | | |
| Mutual Goals | | | | | |
| Any Additional Concerns | | | | | |
| Referral from | | | | | |
| Family/Friend Contact Info  Name  Phone | Relationship  E-mail | | | | |

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Client Signature Date [Title] Signature Date