**INTAKE ASSESSMENT FORM – CARE PLAN**

|  |  |
| --- | --- |
| Name | Date |
| Address | PhoneE-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