Empowerment Counseling Center of Rhode Island

Client Intake Form

Client's name: _____ Date of appointment:_____

Gender: ___ F ___ M Date of birth: _____ Age: _____

Form completed by (if someone other than client): _____

Address: _____Floor/Apt. #:_____

City: _____State: _____Zip: _____

Phone (home):_____ (work):_____ (cell): _____Email:_____

Occupation: _____Employer:_____

Emergency Contact Person:_____Phone:_____

Marital/Relational Status:_____Name of Spouse/Partner_____

Where employed: _____ Work phone: _____Occupation:_____

Physician:_____Address:_____Phone:_____

Referred by:_____Reason:_____

Insurance Information:_____

Primary Medical Insurance:_____ Insurance #:_____

Subscriber Name:_____ Date of Birth:_____ SS#: _____

Secondary Medical Insurance:_____ Insurance #:_____

Current Medications and reason: _____

Health or medical issues:_____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

Clinician:_____Date:_____

Client/Parent/Guardian signature:_____Date:_____