

THE HEALTH AND WELLNESS SOURCE, LLC  
4230 Forbes Blvd. Suite A, Lanham, MD 20706  
NEW CLIENT INTAKE FORM

Client FULL Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

(person being seen today)

Gender: \_\_\_ M \_\_\_ F Marital Status: \_\_\_ Single \_\_\_ Married \_\_\_ Separated \_\_\_ Divorced SSN: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Ph: \_\_\_\_\_ Cell Ph: \_\_\_\_\_ Work ph: \_\_\_\_\_

Email: \_\_\_\_\_ Occupation: \_\_\_\_\_

Parent/Guardian (if a minor): \_\_\_\_\_ Ph: \_\_\_\_\_

Relationship to Client \_\_\_\_\_ Languages Spoken: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone \_\_\_\_\_

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**Services Requested (please check all that apply):**

\_\_\_ Individual Therapy \_\_\_ Family Therapy \_\_\_ Marital/Couples Therapy \_\_\_ Group Therapy \_\_\_ PRP

\_\_\_ Psychiatric Rehabilitation Program (PRP) \_\_\_ Women's Wellness Program \_\_\_ Psychological Testing

\_\_\_ Nutritional Counseling \_\_\_ Acupuncture \_\_\_ Holistic Health & Wellness Coaching

\_\_\_ Financial Wellness Counseling \_\_\_ Child/Adolescent Nutritional Health \_\_\_ Post-adoption counseling

\_\_\_ Academic Tutoring \_\_\_ Ionic Foot Detox \_\_\_ Massage Therapy/Bodywork \_\_\_ Fitness/Weight Loss

\_\_\_ Personal (Fitness) Training \_\_\_ Sports/Athletic Conditioning/Coaching

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Reason(s) for Referral:

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HOW DID YOU HEAR ABOUT US? \_\_\_\_\_ Referred By: \_\_\_\_\_

**Billing Information:**

Name/Type of Insurance: \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_ Co-pay amount: \$ \_\_\_\_\_

Name of Sponsor/Subscriber: \_\_\_\_\_ AUTH# (EAP): \_\_\_\_\_

Other payment source (such as self pay) \_\_\_\_\_

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*By my signature I acknowledge that the information above is true and correct.*

\_\_\_\_\_  
**Client Signature**

(or Parent/Guardian, if under 18)

\_\_\_\_\_  
**Date**