SHIDEH LENNON, PH.D.
CLIENT INTAKE FORM

First Name: ____________________ MI ________

Last Name: _______________________________

Address: _________________________________

____

City: _________________State: ____ Zip: _______

Home Phone:_____________________

Work Phone: _____________________

Date of Birth: ___________________

Sex: ______ Female ________ Male

Soc. Sec.# _______________________

Responsible Party (If other than client)

First Name: ____________________ MI ________

Last Name: _______________________________

Address: _________________________________

____

City:_________________State: ____ Zip: _______

Home Phone: ____________________

Work Phone: _____________________

Date of Birth: ___________________

Sex: ______ Female ________ Male

General Insurance Information

Marital Status
____ Single
____ Married
____ Other

Employment Status
____ Employed
____ Full Time Student
____ Part Time Student

Client Condition Related to:
Employment? ___ Yes ___ No
Auto Accident? ___ Yes ___ No
Other Accident? ___ Yes ___ No

Insurance Company Information

Ins. Co. Name: ___________________________

Address: ________________________________

____

City: ______________ State: ____ Zip: _________

Phone: ____________________________

Fee: $ ____________________________

Copay: $___________________________

Diagnosis: __________________________

Policy Holder (if other than client)

First Name: ______________________________

Last Name: _______________________________

Address: _________________________________

____

City: __________________ State: ___ Zip: ______

Sex: _____ Female _____ Male

Date of Birth: _____________________________

ID Number: ________________________

Policy Number: _____________________

Group Number: ______________________

Authorization Number: _______________

From: ____________ To: ______________

Home Phone: ________________________

Soc. Sec. # __________________________

Secondary Insurance: ____
What is your relationship to the insured? Self _____ Spouse _____ Child _____ Other _____
Are you under your employer's health plan? ___ Yes ___ No

Employer's Name: ____

Insurance Plan Name: ____
Is your signature on File? ___ Yes ___ No