Northshore Center For Wellness, LLC

INTAKE QUESTIONNAIRE

Date ____________________

Name ______________________________________ **Age** __________ **DOB** ______________

SS# ____________________________________ **Sex** ___________ **Race** ____________

Address ____

Home #____________________________ **Cell#** _____________________________

Emergency contact ___________________________ **Phone #**_____________

PCP ____ **Phone #** _______________

School/Employer _____________________________ **Phone #** _______________

<u>Insurance Information</u>

<u>Primary Insurance Provider</u>

Name ____________________________ **Person Insured** ____________________________

Policy #_______________ **Group#** ___________ **Issue date:** _________ **Exp.** ___

<u>Secondary Insurance Provider (if applicable)</u>

Name ____________________________ **Person Insured** _________________________

Policy #_____________________ **Group#**____________ **Issue date:** __________

Exp. _______

Who referred you to N.C.F.W? _________________________________ ______________________

Reason for referral ____

Other agency involvement:

Agency Name ________________________________
Contact ____ **Phone** ________________
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Agency Name ________________________________
Contact ____ **Phone** ________________
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Family Medical History

Please check if the client or family members have experienced any of the following health problems:

Medical problem	Client	Family	Comments FOR STAFF USE ONLY	Medical problem	Client	Family	Comments FOR STAFF USE ONLY
Allergic Rhinitis (Hay fever)				High Cholesterol			
Anemia				High blood pressure			
Arthritis				Kidney Diseases			
Asthma				Lupus			
Birth Defects				Mental Retardation			
Bleeding Problem				Migraines			
Cancer				Miscarriage			
Depression				Arthritis			
Diabetes, Type 1 (childhood onset)				Stroke			
Diabetes, Type 2 (adult onset)				Thyroid Disorders			
Epilepsy (seizures)				Tuberculosis			
Eye Conditions				Ulcers			
Hearing Problems				Other:			
Heart Disease (Coronary)				Other:			

Artery or Heart Attack				other			

Allergies: ______________________________

Current medications/dosage **Purpose**

___________________________ ________________

___________________________ ________________

___________________________ ________________

BILLING AUTHORIZATION

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize Northshore Center For Wellness to release any information required to process my claims.

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___________________________ **Consumer/legal guardian's signature** **Date**