Integrative Health Partners LLC

INFORMATION FORM

Name: ____

Date of Birth: ____________________ Sex: M F (circle one)

Address: ____

City, State: _____________________ Zip: _______________________________

Home Phone: ____________________ OK to leave message? Y N (circle one)

Work Phone: ____________________ Cell Phone: ______________________________

Email: ____

OK to contact you by email? Y N (circle one)

Emergency Contact: __________________________ Phone: __________________________

Are you currently taking medication? Y N (circle one)

Medication/dosage: __________________________ Physician: ________________________

Medication/dosage: __________________________ Physician: ________________________

Medication/dosage: __________________________ Physician: ________________________

Have you been in therapy before? Y N (circle one)

Provider's Name: ____________________________ Phone: ____________________________

Medication/dosage: __________________________ Physician: ________________________

Insurance:____________________________________

Group Number:____________________ ID Number:__________________________________

Insured (if different: ______________________________________ Birth date______________

Responsible Party Information (if different from above):

Name: ____

Date of Birth: ____________________ Sex: M F (circle one)

Address: ____

City, State: _______________________________ Zip: _______________________________

Email: ____

Home Phone: _______________________ OK to leave message? Y N (circle one)

Work Phone: _______________________ Cell Phone: ______________________________