

COMMUNITY REHAB CARE INC.
CLIENT INTAKE FORM

Referral Date _____ Staff Initials _____ NEW / FOP /Other (Circle) Client #: _____

Referral Source: (Person and/or Facility): _____

Address: _____

Phone No#: _____ NRP PT SP OT NP NHI CM OTHER _____

CLIENT NAME :(Last) _____ (First) _____

Address: _____

Phone Number: (Home) _____ (Work) _____

Cell Number: _____ **DOB:** _____

SS#: _____ **Age:** _____

Sex: _____ **Marital Status:** _____ **If hospitalized, fir, room, bed#:** _____

Emergency Contact: _____ **Relationship:** _____

Address: _____

Phone# : (Home) _____ (Work) _____ (Cell) _____

DIAGNOSIS: _____

Date of Onset: _____

REFERRING M.D: (Name & Address) _____

UPIN#: _____ **Phone#** _____ **Fax:** _____

PRIMARY CARE PHYSICIAN: _____

Address: _____

UPIN#: _____ **Phone#** _____ **Fax:** _____

PRIMARY INSURANCE:

Company: _____ **Cert/Subscriber#** _____

Tel # _____ **Contact:** _____

SECONDARY INSURANCE:

Company/Plan: _____ **Cert/Subscriber #** _____

COMMENTS/HISTORY:

How was referral left: _____