

Excelsior Springs, MO 64024 • Office: 816-585-1272 • Fax: 913-285-8134

Initial Intake Form

Identifying Information

Client Name: _____

Date of Birth: _____ Age: _____

Gender: _____

Home Address:

_____

City: _____ State: _____

Zip Code: _____

Email Address:

_____

Client is Currently Living With: Including Siblings

_____

Guardian 1 Name: _____

Relationship to Client: _____ DOB:_____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Email: _____

Guardian 2 Name: _____

Relationship to Client: _____ DOB _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Email: _____

Education

Current School: _____

Grade: _____

Hours Attended: _____

Current Diagnosis/es :

_____

_____

_____

Client's Weekly Availability (including school year)

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Saturday _____

Primary Insurance:

_____

***Please email this form to oholt@bloombhc.com to get your family on the intake list and a copy of the front and back of your insurance card.