# Adult Intake Form

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PLEASE PRINT

Patient's Name: _____ (First MI Last) Birthdate: ___/___/___ (Month Day Year)

Home Address: _____ (Street) _____ (City) , _____ (State Zipcode)

Billing Address: _____ (Street) _____ (City) , _____ (State Zipcode)

Home Phone: _____-_____ Email:(optional) _____

Cell Phone: _____-_____ College/ University: _____

Business Phone: _____-_____ Employer: _____

Reason For Visit: _____

Referred by: _____

Current Medications: _____

Physician Information: _____

Medical History: _____

_____

Previous Testing/ Treatment: _____

_____

**Email address where report is to be sent to:** _____

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