Intake Form for Healing & Recovery Groups

Name _____ DOB _____ Age _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Occupation _____ Highest Level of Education _____

Email _____

Emergency Contact _____ Phone Number _____

Address _____

City _____ State _____ Zip _____

Relationship _____

Physician _____ Phone Number _____

Referred By _____

Address _____

City _____ State _____ Zip _____

Will this person need to be contacted? _____

May we send information about this program? _____

With whom are you living now? List people and relationship (s):

_____

_____

Please list medications:

_____

_____