



Please circle what applies:
Language: Spanish or English
Gender: Male or Female

Intake Request Form

Date: _____ Client Name: _____ Client Age: ____ DOB: _____

Client's Background Information: _____

Substance Abuse Issues/Mental illness (if applicable): _____

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Medicaid/PeachCare #: _____ SS# _____
 (if Medicaid/PeachCare # is not available)

Referral Source: _____

Referral Source Name: _____

Referral Source Phone #: _____

Referral Source Email Address: _____

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Parent/ Legal Guardian: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

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FOR OFFICE USE ONLY

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Completed by: _____ Date: _____ Time: _____

Distributed To: _____ Faxed Emailed Phoned Person

Date Distributed: _____ Time Distributed: _____

Please mail, phone or fax in your request!

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