

Case Management Intake Form

PATIENT INFORMATION

Full name:: _____ Date of birth:: _____ dd / mm / yyyy
Gender:: _____ Phone number:: _____
Email:: _____ Address:: _____

EMERGENCY CONTACT

Name:: _____ Phone number:: _____
Relationship:: _____

MEDICAL HISTORY

Primary care physician:: _____

Major illnesses/conditions:

Current medications:

Allergies:: _____

Other (e.g. family history of major conditions):

CURRENT HEALTH

Reason for seeking care:

Symptoms/concerns:

Previous treatments:

Current lifestyle habits (sleep, alcohol consumption, exercise, nutrition etc.):

INSURANCE INFORMATION

Insurance provider:: _____ Policy number:: _____

Group number:: _____

GOALS AND EXPECTATIONS

Patient health goals:

Expectations from case management:

Preferred communication style:

ADDITIONAL NOTES

Specify below: