Pre-assessment Worksheet

Name: ______________________________ **Date:**_________________________________

Age: _________________ **DOB:** ________________________________

Address: ____

Phone Number(s): (c) _________________ (h) __________________ (w)__________________

Family/Emergency Contact Information: ** denotes legal guardian/ power of attorney

Name	Address	Phone number	Relationship

Primary Insurance Information:

Policy name and type:____

Policy number: ____

Secondary Insurance Information:

Policy name and type:____

Policy number: ____

Allergies (list allergen and reaction):

Allergen	Reaction

Known Diagnoses:____

Pharmacy Name:_______________________________________ **Number:**_________________________

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Medications:

Name	Medication	Frequency (daily, twice a day, etc.)

Practitioners:(primary care, specialist, dentist, optometrist,…etc)**:**

Name	Specialty	Phone number

Billing info:

Bill to: ____

Address: ____

____

Phone: ____________________ Email: ____

Completed by: ________________________ **Relationship to client:** _____________________