

Referring Site:	
Referring Clinician:	
Clinician's Contact Information:	
Date:	
Full Name:	
DOB:	
SS#:	
Phone Number:	Home: Cell:
Physical Address:	Street AddressApt/Suite CityStateZip Code
Mailing Address	Same as Above: Street Number/StreetApt/Suite City State Zip Code Can we send mail? Yes No
Email:	N/A
Gender:	Male Female Other Prefer Not to Say
Race:	
Ethnicity:	
Living Status:	(Independent, with spouse, with relative, residential facility, homeless, etc.)
Marital Status:	
Tobacco Use:	User Non-User Unable to Collect
Smoking Status:	Current Past Never

	(Diagon and if your other language then English)
Primary Language:	(Please specify any other language than English)
Military Status:	None
Employment:	Not Employed Full-Time Part-Time Actively Looking
Education:	(Highest Level Completed)
Annual Household Income:	\$Source of Income (Child Support, Wages, Public Assistance, Disability, etc.)
Household Information:	Number of Individuals in Household: Members Under the Age of 18:
Insurance Information:	Uninsured
Presenting Issue:	
If an earlier appointment becomes available, would you like us to contact you?	YES NO
Do you have the ability to receive services electronically (i.e. telehealth services, video appointments, etc.)?	Yes No

PLEASE FAX FORM TO NCCC INTAKE: (614) 267-7013 OR EMAIL - INTAKE@NORTHCOMMUNITY.COM