NORTH TEXAS
HEALING CENTER

PATIENT INTAKE FORM

PATIENT INFO

First Name: _____ **Middle Name:** _____

Last Name: _____ **Preferred Name:** _____

Birthdate: _____ **Age:** _____ **Occupation:** _____

Gender: Male ☐ Female ☐ Other ☐

Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐

Partner's Name: (if applicable) _____ **Number of Children:** _____

Height: Feet: _____ Inches: _____ **Weight:** Lbs: _____

Preferred Language: _____

CONTACT INFO

Email: _____ **Phone:** _____

☐ *I consent to receive appointment reminders/notifications from North Texas Healing Center.*

Address: _____

City: _____ **State:** _____ **Zip:** _____

Secondary Address: _____

City: _____ **State:** _____ **Zip:** _____

EMERGENCY CONTACT INFO

Emergency Contact Name: _____

Emergency Contact Phone: _____ **Relationship to Patient:** _____

REFERRAL INFO

Referred by: _____

ACKNOWLEDGEMENT

The information above is complete and true to the best of my knowledge.

Signature: _____ **Date:** _____