CRAIG A. FAHEY
ATTORNEY AT LAW

New Client Intake Form

NAME:_____ DATE OF BIRTH:_____

SSN:_____ PHONE:_____

ADDRESS:_____

YOUR MEDICAL HISTORY

MEDICAL PROVIDER: MD / HOSPITAL / LAB	ADDRESS PHONE FAX	DATES OF TREATMENT	MEDICAL CONDITION TREATED

YOUR WORK HISTORY

JOB TITLE	TYPE OF WORK	DATES OF EMPLOYMENT FROM	TO

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Current Medications

NAME OF MEDICATION	DOSAGE (MG/CM)	FREQUENCY TAKEN	PRESCRIBING DOCTOR'S NAME	PURPOSE AND SIDE EFFECTS