RISPERDAL INTAKE FORM

Date:_____

I. Client Detail

Name:_____

Primary Phone:_____

Cell Phone:_____

Email:_____

Address: _____

City_____ State: _____ Zip:_____

Date of Birth:_____ SSN:_____

II. Secondary Information

Name:_____

Relation:_____

Legal Guardian of Risperdal user:_____

Is user of minor, autistic, ect:_____

III. Risperdal Details

Date Started:_____

Date Stopped:_____

Prescribing Doctor name:_____

Address: _____

City_____ State: _____ Zip:_____

Primary Phone:_____

Pharmacy:_____

Diagnosed with Gynecomastia?_____

If yes, Name and address of diagnosing Doctor:_____

Has He/She had Surgery? Yes___ No___

If Yes, Name of hospital:_____

Address: _____

City_____ State: _____ Zip:_____

Primary Phone:_____

IV. Previous Attorney

Previous Law firm:_____

Attorney Name:_____

Reason for seeking new representation:_____

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