

INTAKE INFORMATION

Name _____ Birthdate _____ Sex (circle) Female Male

Address _____ Soc. Sec. # _____

_____ Home Phone _____

_____ Cell Phone _____

Occupation (circle): Employed Student Other _____

Employer or School _____ Phone _____

Address _____ Extension _____

_____ Who referred you? _____

Primary Care Doctor _____ Phone Number _____

Date of last physical ____/____/____ Medications _____

History

Presenting Problem _____

Previous Psychotherapy (circle) yes no If yes, when/whom? _____

Major Illnesses _____

Significant Other and Family Members

Name	Birthdate	Relationship	Living at home	
_____	_____	_____	yes	no
_____	_____	_____	yes	no
_____	_____	_____	yes	no
_____	_____	_____	yes	no
_____	_____	_____	yes	no

PERSON RESPONSIBLE FOR THE ACCOUNT _____

Address _____ Phone _____

Signature _____ Date _____

In case of an emergency, contact _____ Phone _____