INTAKE INFORMATION **Todays Date: _____**

Patient's Name: _____ Patient's DOB _____

Patient's Address_____
Street City State Zip

Phone with Area Code: Cell _____ Okay to leave a voice message? _____

Work _____ Okay to contact you/leave message? _____

Personal Email: _____ Okay to email to this address? _____

Living Status: ____ Single ____ Married ____ Divorced ____ Separated ____ Widowed

Employer _____

Work Email: _____ Okay to send mail to this address? _____

Spouse's/Partner's Name _____ Date of Birth _____

Address _____
Street City State Zip

Employer _____

Phone with Area Code: Cell _____ Okay to contact you/leave message? _____

Work _____ Okay to contact you/leave message? _____

Please list additional family members living with you:

Name Relationship Date of Birth Employer/School

1. _____
2. _____
3. _____

Physician _____
Name Address Phone #

SS# _____ Payment Method _____ Billing Zip Code _____

Name on Card: _____ Expiration Date: _____

Credit/Debit Card # to be retained on file: _____ CVC # _____

Name of Referral Source: _____

I agree to allow my therapist to inform my referral source that I have attended an initial session

Yes _____ No _____ Signature: _____