

## PATIENT INTAKE FORM

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<i>Full Name:</i>					
<i>Date of Birth:</i>					
<i>Address:</i>					
<i>City:</i>		<i>State:</i>		<i>Zip Code:</i>	
<i>Telephone (Home):</i>					
<i>Telephone (Work):</i>					
<i>Telephone (Cell):</i>					
<i>Marital Status:</i>		<i>Children:</i>			
<i>Are you currently being treated for any medical condition?</i>					
<i>Have you received psychological treatment in the past?</i>					
<input type="checkbox"/> <i>No</i> <i>Not Applicable</i>					
<input type="checkbox"/> <i>Yes</i> <i>How long ago? Whom did you see?</i>					
<i>Who referred you?</i>					
<i>What are your goals for therapy?</i>					
<b><i>Services are payable when rendered, be advised there is a 24 hour cancellation policy. Please sign that you are responsible for such payments.</i></b>					
<b><i>Signature:</i></b>					
<b><i>Date:</i></b>					