PATIENT INTAKE FORM

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Full Name:					
Date of Birth:					
Address:					
City:		*State:*		*Zip Code:*	
Telephone (Home):					
Telephone (Work):					
Telephone (Cell):					
Marital Status:		*Children:*			

Are you currently being treated for any medical condition?

Have you received psychological treatment in the past?

☐ *No* *Not Applicable*

☐ *Yes* *How long ago? Whom did you see?*

Who referred you?

What are your goals for therapy?

Services are payable when rendered, be advised there is a 24 hour cancellation policy. Please sign that you are responsible for such payments.

Signature:

Date: