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PATIENT INTAKE FORM

Name:_____ Date:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Phone: Home:_____ Work:_____ Cell:_____ (* Preferred)

Birthdate:_____ Age:_____ Email:_____

Employer:_____ Occupation:_____

Referred by:_____

Briefly describe problem(s) for which you are currently seeking help:_____

_____

_____

Have you been in therapy previously? YES NO (Circle one)

If yes, with whom, when, for what?_____

_____

Primary Care Physician Name:_____

Address:_____ Phone: _____

Date of last physical: _____

Please briefly list any past or present medical issues:_____

_____

Psychopharmacologist Name:_____

Address:_____ Phone: _____

Current Medications:_____

Emergency Contact Name:_____Phone: _____

Relationship to you:_____

If you are **NOT** the primary insurance subscriber, please provide the name and date of birth of the person who is:

Name:_____ Date of Birth:_____