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Name: _____ Date of birth: _____

Address: _____

Please star the numbers where I may leave a specific message for you and put an X next to the numbers where you do not want me to leave a specific message.

Telephone: Home: _____

Work: _____

Cell: _____

Email: _____

Referred by: _____

May I use your name when I thank the person who referred you? ____yes ____no

Emergency contact name: _____

Emergency contact number: _____

Family members names and ages: _____

Your profession: _____

Education: _____

Name(s) and number(s) of other healthcare providers you are working with: _____

Do you have any physical or medical problems? _____ If yes, please describe: _____

Are you currently taking any medication? _____ If yes, please indicate names, dosage, frequency, and start date:

Have you at any time been on medication for a mental health problem? _____ If yes, please indicate names, dosage, frequency, and start/end date:

Have you ever seen a therapist before? _____ If yes, please describe _____

Reason for contacting me: _____
