CLINICAL INFORMATION

First Session_____

Name_____ Phone Number(h)_____

Address_____ Phone Number (w)_____

Cell_____E-mail_____

City/State/Zip_____ Cell #_____

Employer_____Occupation_____

Birthdate_____Age_____Education/Degrees_____

Physician_____ Referred by_____

Previous/Current Therapist(s) & Dates (Includes individual, group, couples, family)

_____

Last Physical Exam_____ Concerns_____

Current Medications and Dosage_____

Significant Medical &/or Psychiatric History_____

_____

If you have a partner/spouse please list their name, age and occupation_____

_____

Children's Name and Ages (indicate if not living at home)_____

_____

Briefly Describe Your Reason(s) for Seeking Therapy at this Time_____

_____

Please read and sign the Intake Agreement and bring both forms to your first session. Thank you.