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Clinical Psychologist

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INTAKE INFORMATION SHEET

Name_____ Date of Birth_____

Email Address_____

Home Phone_____ Cell Phone _____
Please circle the best number to reach you.
Is it ok to leave a message on this phone number? Yes_____ No_____

Home Address_____
Street City, State, Zip

Place of Employment_____

Employer_____ Occupation _____

Marital/ Relationship Status _____

Emergency Contact_____ Relationship_____

Phone number of Emergency Contact_____

Referred by_____

Do you give me permission to acknowledge the referral? Yes____ No____

IF PATIENT IS A MINOR

Parent or Guardian Responsible for Account: _____

Home Address_____

Phone_____ Email Address_____

The undersigned accepts responsibility for the cost of all services rendered to the patient and attests that the information given is true and correct. The undersigned further understands that APPOINTMENTS MUST BE CANCELLED NO LESS THAN 48 HOURS PRIOR TO THE SCHEDULED TIME OR THE FULL FEE WILL BE CHARGED.

Signature_____ Date _____

Parent Signature (if minor)_____Date _____

Parent Name (please print) _____