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# INTAKE FORM

DATE_____ DX:_____
(Doctors Use Only)

PLEASE PRINT

First Name_____ MI____ Last Name_____

Home Phone#_____ Cell#_____

Address_____

City_____ State_____ Zip_____

SSN#_____ Birth Date _____

Email _____

Emergency Contact _____ Relationship_____

Address_____ Phone _____

**********

Insurance Company_____

ID#_____ Group#_____

Address _____ Phone_____

***If you are not the subscriber please fill in:

Subscriber's Name_____Birth Date_____SSN#_____

**********

Family Physician_____ Date of last visit_____

Address_____ Phone #_____

List all Medications _____

Previous Therapist_____ From _____ to _____

Address _____ _____Phone# _____

May I consult your previous therapist? Yes/No I was referred by _____

*Thank you for this information. The more I know, the more I can be of help to you*