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Intake Form for Private Psychotherapy

Name: _____ Date: _____

Address: _____ DOB: _____

City: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Employer: _____

Married ___ Single ___ Divorced ___, for how long? _____

Referred by: _____

Insurance Billing: _____ Yes _____ No

Previous psychotherapy? _____ Yes _____ No

When? _____ With Whom? _____

Are you currently taking any medications? _____ Yes _____ No

If so what medication(s), dosage _____

Signature

Date

Therapist

Date

Names of the Children and their ages:

