Client Intake Form (All information is strictly confidential)

Name: _____ Date: _____

Address: _____

Please include all information for mailing address, and please include your postal code)

Email address (please print) _____

Phone number (home): _____ (bus): _____ (cell): _____

Birth date: ___/___/___ Employer: _____ Occupation: _____

Credit Card: VISA/MASTERCARD _____Expiry ___/___

CV Code (3 digits on back): _____ (FULL NAME ON CARD_____

How did you hear about me? _____

Why are you here? _____

Have you received any medical or psychological treatment during the past year? ___Y___/___N___

If yes, please describe: _____

Have you had any prolonged illness? _____

Have you ever been treated for (check all that apply):
_____ Epilepsy _____ Dissociative Disorder _____ Heart Problems _____None

Describe: _____

Are you currently taking prescribed medication? Y / N

If so, what?_____ Dosage? _____

Name of Physician / Psychologist: _____ Telephone: _____

Describe any previous efforts to solve this problem: _____

Please be advised, I have a 48-hour cancellation policy. Clients who do not notify me of cancellations within this time will be charged the full amount for their appointment.

Client Signature: _____

Client acknowledges understanding this questionnaire, and all information provided is accurate and complete to the best of Client's knowledge and that all of the outcomes of the session are totally the client's responsibility.

Would you like to be on our mailing list? Y / N