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Patient Intake Information

Date: _____

Name: _____

Home Address: _____

Home phone: _____ Cell phone: _____ Office phone: _____

Age: _____ Date of Birth: _____ Social Security #: _____

Occupation: _____ Employer: _____

Employer's address: _____

Marital Status: S M W D e-mail address: _____

Name of Spouse: _____

Spouse's Occupation: _____ Spouse's Social Security #: _____

Home phone: _____ Cell Phone: _____ Work Phone: _____

Are you presently seeing another therapist? Yes No

Other Members of Household:

Name:	Age:	School/Occupation:	Grade:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Referred by: _____

Emergency Contact: _____

Date of last physical examination: _____ **Doctor:** _____

What medications are you taking, even occasionally? _____

In the last month, how many hours of deep and restful sleep did you average each night?

1-2 2-4 4-5 5-6 7-8

PAYMENT EXPECTED AT TIME OF VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE WITH DR. DAVIS:

Person responsible for payment: _____

Address & phone number (if different from patient): _____

Insurance Company: _____

Insured's name: (If different from patient): _____

Insured's Social Security Number: _____