INTAKE INFORMATION & CONSENT

Name: _____ Soc Sec #: _____
(Last) (First) (M.I.)

Spouse/Partner (Name) (DOB): _____

Address: _____
(Street) (City) (State) (ZIP)

Mailing Address: _____

Phone: _____
(Home) (Cell) (eMail)

Age: _____ Birth date: _____ M / F Education: _____ Marr / Sep / Div / Single

Occupation: _____ Employer: _____

Children (Name/Age): _____

Parents (Age/Marital Status/'StepsParents'): _____

_____

(**If** Deceased: Age/Cause): _____

Brothers/Sisters w/ age: _____

Current Household members: _____

Medical (surgeries/illness/current concerns): _____

_____

Emergency Contact/Phone: _____

Physician: _____ Medications: _____

Previous Therapy/Treatment: _____

Person or Agency who referred you: _____

I have discussed Professional Policies with Paul Gessford MFT, including lengths of sessions and treatment, confidentiality and exceptions, payment of fees and use of insurance, cancellation arrangements, emergencies and telephone contact, and I authorize Paul Gessford MFT to provide psychotherapy for me and/or my dependent.

Signature: _____ Date: _____
(Client / Legal Guardian)

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