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Intake Form

Date: _____

Name: _____

Email: _____

Address: _____

Phones: _____

Date of Birth: _____

Medical Conditions: _____

Psychiatric Medications: _____

Name and Age of Significant Other/Spouse: _____

Names and Ages of Children/Stepchildren: _____

Current or Prior Psychotherapists, Psychiatrists, Counselors. Please give approximate dates:

How were you referred? _____

All information will be kept strictly confidential.