Cherie Baetz-Davis, Ph.D., LLC

INTAKE INFORMATION

Client: _____ Sex: ____ Age: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

ADULT CLIENTS, complete the FOLLOWING BOX and the LOWER PORTION:

Home #: _____ Cell #: _____ Email : _____

Employer: _____ Position: _____ Work #: _____

Significant Other: _____ Sex: ____ Age: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Email : _____

Employer: _____ Position: _____ Work #: _____

FOR CHILD/ADOLESCENT CLIENTS, complete the FOLLOWING BOX and the LOWER PORTION:

School: _____ Grade: _____ Teacher/Counselor: _____

Parent/Guardian: _____ Home #: _____ Cell #: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Employer: _____ Work #: _____

Parent/Guardian: _____ Home #: _____ Cell #: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Employer: _____ Work #: _____

Primary Physician: _____ Phone: _____ Fax: _____

Psychiatrist: _____ Phone: _____ Fax: _____

Medical Conditions: _____

Current Medications/Herbal Supplements: _____

Referred by: _____ Allergies: _____

What are you hoping to gain from services? _____

_____

Prior counseling? _____ When: _____ Where: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

I consent for Cherie Baetz-Davis, Ph.D. to provide evaluation and/or treatment of _____

Client Name

_____ _____

Client/Guardian Signature *Date*