Teresa Bailey, Ph.D.
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Intake Information Form

Name ____ Date ______/______/_________

If Client/Patient is a Child, Parent's Name____

Client/PatientDate of Birth:Month______Day____Year_______Age________Grade_______

Address____ Daytime Phone___________________

____ Evening Phone ____________________

Occupation ____________________________________ Cell Phone ________________________

Employer/School_________________________________ Email______________________________

Employer's Address ____________________________ Education Level ___________________

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Family Status: Single____ Partnered____ Married____ Separated ____ Divorced_______

Widowed____ Number of Children ____ Ages _________________________

Children live with Both Parents ____ Mother ____ Father ____ Other ___

Name of Spouse or Partner____

Spouse or Partner's Occupation _________________________Email_______________________

Personal Physician _______________________________________ Phone ____________________

Address____

Medical Conditions currently being treated ____

Current Medications, if any ____

Referred by ____

Previous therapist(s), if any ____

Problems or issues that prompted you to make an appointment _______________________

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