

Patient Information

Name:						
	First	MI	Last			
Nickname:						
Date of Birth:						
Your Address:						
City, State, Zip:						
Mobile Phone: Okay to Leave	Messages? (please ci	rcle):	No	Text	Voicem	nail
Home Phone: Okay to Leave	Messages? (please ci	rcle):	No	Text	Voicen	nail
Work Phone: Okay to Leave	Messages? (please ci	rcle):	No	Text	Voicen	nail
Preferred Phon	e (please circle):	Mobile	е Н	ome	Work	Other
Email Address:						
Appointment R	eminders (please circ	-	Yes nail	No Text	Both	
Parent/Guardic	ın Information, if appli	cable	(minc	r clien	ts only):	
Name: _						
Relationship: _						
Phone: _						
Email: _						
Appointment R	eminders (please circ		Yes nail	No Text	Both	
In case of Eme	rgency, please contac	ct:				
Name: _						
Relationship: _						
Phone: _						
Please sign to g	give consent to conta	ct abo	ve in	case c	of emerg	gency ONLY.
Signature: _						

(For Staff Use Only - To be discussed during intake session) Birth Sex:
□ Female □ Unknown
Gender Identity: Male Female Transgender Male/Trans Man/FTM Transgender Female/Trans Woman/MTF Genderqueer; neither exclusively male nor female Additional gender category or other; please specify: Choose not to disclose
Sexual Orientation: Lesbian, gay or homosexual Straight or heterosexual Bisexual Something else; please describe: Unknown Choose not to disclose
Race: American Indian or Alaska Native Asian Black or African American Hispanic or Latino Native Hawaiian or Other Pacific Islander White Choose not to disclose
Marital Status: Married Single Other
Employment: □ Employed □ Full-Time Student □ Part-Time Student □ Unemployed/Other
Spirituality/Religious Affiliation: