

**Barbara Dunn, PhD, LICSW, MT-BC
Psychotherapy Practice • Intake Form**

Date _____
Your name _____ DOB _____
Home address _____
City _____ WA ___ Zip Code _____
Home phone _____ Work phone _____
Cell phone _____ Message OK? _____

Children

Name _____ Age _____ Lives at home? _____
Name _____ Age _____ Lives at home? _____
Name _____ Age _____ Lives at home? _____

Spouse/Partner

Name _____ Age _____ Phone _____
Home Address (if different) _____

Person to contact in case of emergency (if different from Spouse/Partner)

Name _____ Phone _____

Medical Information

Doctor _____ Phone _____
Current Medical Conditions/Diagnosis _____

Medication _____ Dosage _____
Medication _____ Dosage _____

Insurance Co _____ Policy # _____

Occupation _____

Referred by _____

Purpose for seeking therapy at this time _____

Therapy goals _____

Other important information _____

(Please use other side of page for additional information)