PATIENT INFORMATION
DO NOT EMAIL

Name: _____

Address: (ok to send mail to this address? Y/N)_____

_____

Telephone Numbers: (days) _____ ok to leave message? Y N
(evenings) _____ ok to leave message? Y N
(cell) _____ ok to leave message? Y N

Person to contact in case of emergency including phone number and relationship: _____

_____

General Physician: _____ Phone: _____

May I contact your physician to let him/her know you are in therapy and to request any relevant information? Y N

Your age: _____ Date of Birth: _____ Occupation: _____

Gender Identity_____ Sexual Identity_____Marital Status: _____

Any children? If so, how many, how old? _____

Whom do you live with? _____

Are you eligible for Medicare? Y N

How did you hear about me (check any that apply)?

- ☐ Referred by another clinician:_____
- ☐ Academy of Cognitive Therapy (ACT)
- ☐ OC Foundation
- ☐ Association of Behavior and Cognitive Therapy (ABCT)
- ☐ Web search (what search words):_____
- ☐ Lyra: Member's name, company, and date of birth_____
- ☐ Modern Health: name, company, work email_____
- ☐ Other:_____