Office of Harmony Satre, PsyD
Licensed Psychologist, PSY22871

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INTAKE FORM - ADULT

Name ____Date of Birth_____________Age_____
Occupation____Today's Date___________________
Address ____
City___________________________________State_____________________Zip________________
Home phone _____________________Cell phone______________________Messages Ok?_______
Fax______________________________Email____
Primary Language______________________________Ethnicity______________________________
Social Security Number____

EMERGENCY CONTACT
Name___________________________Relationship______________________Phone_____________

Other members in household

Name	Age	Relationship to Client

REFERRAL INFORMATION
Referred by____________________________________Relationship___________________________

Referral questions/concerns (why are you here today?)

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How bothersome are the current symptoms?

On a good day 0--100

On a bad day 0--100

0= not bothersome **100 = unbearable**

HEALTHCARE INFORMATION

Have you ever sought help for this issue before? If yes, was the result?______________________________

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Primary Care Doctor____Phone_______________________

Other Service Providers:

Name/Service Provided (Previous Therapy, etc)	Dates	Contact Information

Current Medications: Name Dosage Duration

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Family Mental Health History____

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Major Illnesses/Surgeries____

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Traumatic Events/Transitions/Recent Life Changes____

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Allergies____

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_________________________ _________________________ _____________________

Completed by (Print Name) Signature Date

Fax completed form to Dr. Satre at 510-288-0444