Center for Cognitive Psychotherapy

Salvatore Ridente LPC, LCADC, Ed.S

I N T A K E F O R M

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential. Please fill out this form and bring it to your first session.

Name: _____
(Last) (First) (Middle Initial)

Birth Date: _____/_____/_____ Age: _____ Gender: □ Male □ Female
Address: _____ City _____ Zip_____

Home Phone: (_____) _____ May we leave a message? □Yes □No
Cell/Other Phone: (_____) _____ May we leave a message? □Yes □No

Email: _____ May we email you? □Yes □No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Marital Status:
□ Never Married □ Domestic Partnership □Married □Separated □Divorced □Widowed

Please list any children/age: _____

Name of Parent/Guardian (**if under 18 yrs**):_____

Referred by (if any): _____

EMERGENCY CONTACTS:
Name_____ Relationship _____
Contact Type: __PCP ___Emergency Contact ___Guardian
Release of Information: ___ Yes ___No ___ Emergency Info ONLY Date _____
Address _____ City_____ Sate _____ Zip _____
Phone # _____ Cell _____

EMERGENCY CONTACTS:
Name_____ Relationship _____
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