PATIENT INTAKE FORM
Penny Spector-Shleifer, LCSW|License No. 44SC05672500

Full Name:	
Date of Birth:	
Address:	
City, State, Zip Code:	
Telephone (Home):	
Telephone (Work):	
Telephone (Cell):	
Marital Status:	
Children:	

Are you currently being treated for any medical condition?

Have you received psychological treatment in the past?

- ❑ No Not Applicable
- ❑ Yes How long ago? Whom did you see?

Who referred you?

What are your goals for therapy?

Services are payable when rendered, be advised there is a 24 hour cancellation policy. Please sign that you are responsible for such payments.

Credit Card (Visa, MasterCard, American Express, Discover, etc.): _____

Card Number: _____ Exp. Date: _____

Billing Address (if different than above): _____

City: _____ State: _____ Zipcode: _____

Signature: _____ Date: _____