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INTAKE REGISTRATION FORM

Today's Date:________________

Your Name(s):____

Address(es)/Postal Code:____

Email(s): ____

Home Phone: (____)__________message ok?___(y or n?) Cell Phone: (____)___________message ok?___
Work Phone: (____)_________message ok?___

Date(s) of Birth: ____

Emergency Contact Name: _______________________ Phone:(____)____________ Relation: ___________

How did you find out about Maria?______________________________if web what site?________________

May I have your permission to thank this person for the referral?___(y or n?)

Have you seen a counsellor before? (y or n?)____ What made it meaningful?_________________________
____

What are you looking for now?____
____
____

I believe that the best care is provided when health care practitioners are aware of one another. With your written consent below, I would like to send your physician or other health care practitioners a pamphlet from my office. In no way would they know you are seeking counselling with me. In taking your confidentiality seriously I will always ask you to sign a separate consent should I ever need to speak directly with anyone about you.

Dr. Name(s): ____

Phone: (____)_________ and/or Address:____

Other Health Care Practitioners *(Psychiatrist, Specialists, Naturopath, Dentist, Chiropractor, etc.)*:

Dr. Name(s): ____

Phone: (____)__________ and/or Address:____

Thank you.