

Lena Rachel Freed, M.S.

INTAKE INFORMATION

Client's Information:

Last Name: _____ First Name: _____ M.I.: _____

Street: _____

City: _____ State: _____ Zip: _____

Phone: _____

Date of Birth: _____ Gender: _____ Sex assigned at birth: M F I

Marital Status: S M D W CU

Employer: _____ Occupation: _____

Person to Contact In Case of an Emergency:

Name: _____ Relationship: _____ Tel: _____

Contact Information for Clients under 18 years of Age:

Guardian/Parent: _____

Home Phone: _____ May I leave a message at this number? Yes No

Cell Phone: _____ May I leave a message at this number? Yes No

Work Phone: _____ May I leave a message at this number? Yes No

Email: _____

Additional Guardian/Parent: _____

Home Phone: _____ May I leave a message at this number? Yes No

Cell Phone: _____ May I leave a message at this number? Yes No

Work Phone: _____ May I leave a message at this number? Yes No

Email: _____

Additional Guardian/Parent: _____

Home Phone: _____ May I leave a message at this number? Yes No

Cell Phone: _____ May I leave a message at this number? Yes No

Work Phone: _____ May I leave a message at this number? Yes No

Email: _____

School Information:

School: _____ Grade: ____ Teacher: _____

Classroom Setting: _____

IEP: Yes No

Interventionist: Yes No

504 Plan: Yes No

Referral Source:

Referring Physician: _____

Physician's reason for Referral:

Please take a moment to explain the reasons you are seeking psychological support. What concern(s) is/are bringing you and/or your child into care?

Goals for Treatment:

Please explain what you are hoping to gain from treatment.

Person Completing Form: _____

Date: _____