Jessica D. Getson, LPC, DBTC
Positive Therapy for Personal Healing

CLIENT INTAKE FORM

Legal Name **DOB** **Age**

Nickname/what you prefer to be called (if different from above)

How did you hear about my practice? (Referred by…, Internet, etc.)

Permanent Street Address **City** **State** **Zip**

Temporary Street Address (if different from above) **City** **State** **Zip**

Which address is best for me to send you mail? **Permanent** ☐ **Temporary** ☐

Home Phone **May I call? Yes No** **May I leave message? Yes No**

Cell Phone **May I call? Yes No** **May I leave message? Yes No**

Work Phone **May I call? Yes No** **May I leave message? Yes No**

Personal Email Address **May I email? Yes No**

Work/School Email **May I email? Yes No**

Would you like me to send your invoice receipts electronically via email? **Yes No**

Emergency Contact

Name (if client is a minor, parent/guardian) **Relationship**

Street Address **(Apt #)** **City** **State** **Zip**

Home Phone **Cell Phone**

Work Phone **Email**

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Your Family Doctor

Name **Phone**

Street Address **City** **State** **Zip Code**

Would you like for me to contact the above specialist for the purpose of collaborating in your care? Yes No

List any additional specialists below from whom you are currently receiving treatment (psychiatrist, nutritionist, treatment facility as examples)

Name **Phone**

Street Address **City** **State** **Zip Code**

Would you like me to contact the above specialist/facility for the purpose of collaborating in your care? Yes No

Name **Phone**

Street Address **City** **State** **Zip Code**

Would you like me to contact the above specialist/facility for the purpose of collaborating in your care? Yes No

Name **Phone**

Street Address **City** **State** **Zip Code**

Would you like me to contact the above specialist/facility for the purpose of collaborating in your care? Yes No

By signing below, you are:

1) **confirming that you have completed this form fully and accurately**
2) **giving me permission to contact any specialists you provided and circled 'yes' for me to collaborate in your care. This may involve sharing treatment summaries, progress notes, evaluations and having verbal discussions for the purpose of facilitating treatment.**
3) **acknowledging that you have fully read the ' Informed Consent Form' (additionally given with this form) and agree with all of its content**

Client or Responsible Party Signature **Date**