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

CLIENT INTAKE FORM

Legal Name _____ DOB _____ Age _____

Nickname (if applicable) _____

How did you hear about me? (Doctor, Internet, etc.) _____

CONTACT INFORMATION

_____
Permanent Street Address City State Zip

_____
Temporary Street Address City State Zip

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

Home Phone _____-_____-_____

Cell Phone _____-_____-_____

Work Phone _____-_____-_____

**Indicate if there is a preferred telephone number: Home ☐ Cell ☐ Work ☐*

Personal Email _____

Work Email _____

School Email _____

**Indicate if there is a preferred email: Personal ☐ Work ☐ School ☐*

** May I send you receipts via email? Yes ☐ No ☐*

EMERGENCY CONTACT

_____
Name Relationship

_____
Street Address City State Zip

_____
Home Phone Cell Phone Email

CLIENT INTAKE FORM

DOCTORS/SPECIALISTS (Internist, Psychiatrist, Dietician, Treatment Center, etc.)

1…

Name Phone

Street Address City State Zip

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

2…

Name Phone

Street Address City State Zip

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

3…

Name Phone

Street Address City State Zip

**Would you like for me to contact above doctor 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 for whom you have provided information and circled 'yes' for the purpose of collaborating in your care.

3) acknowledging that you have fully read the 'Informed Consent & Responsibilities' document (additionally given with this form) and agree to comply with all of its content.

Client or Responsible Party Signature Date