TREAT NYC
Psychology Therapy Services PLLC

CLIENT INTAKE FORM

Client Legal Name:_____ DOB: ____/____/_____ Age: _____

Client Preferred Name:_____ Gender: _____

Address:_____

Phone: (_____) _____ Email: _____

Emergency Contact Information

Name:_____ Relationship to client:_____

Phone: (_____) _____ Email: _____

Name of Primary Care Physician: _____

Address: _____

Phone: (_____) _____

Is client currently taking prescribed psychiatric medication? YES NO

If yes, please list: _____

Prescribed by: _____