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Contact Information

Please complete this form before our first session. Your answers here tell me how, and how discreetly, I may reach you.

ABOUT YOU

Legal first name | Legal last name | Preferred name

Pronouns (optional) | Date of birth (MM/DD/YYYY) | Occupation

Street address | Apt / Unit

City | State | ZIP

HOW TO REACH YOU

Mobile phone | Other phone

May I leave a detailed voicemail at your mobile number? ◯ Yes ◯ Brief message only ◯ No

May I text you about scheduling? (No clinical content by text.) ◯ Yes ◯ No

Email address

May I email you about scheduling, billing, and forms? ◯ Yes ◯ No

Preferred way to be contacted: ◯ Mobile call ◯ Text ◯ Email

EMERGENCY CONTACT

Someone I may contact only if I believe you are in immediate danger, or if I cannot reach you during an emergency in a telehealth session.

Name | Relationship | Phone

OTHER CARE

Primary care physician | Phone

Psychiatrist or prescriber (if any) | Phone

GETTING STARTED

How did you find me?

☐ Website / search ☐ Psychology Today ☐ GoodTherapy ☐ Referral from a clinician ☐ Friend or family ☐ Other

If referred, by whom (optional)

State you will usually be in during sessions

Time zone

Patient signature (typed full name serves as signature)

Date

Printed name

Date of birth