# Alison Godby Ligocki, Ph.D.

**New Patient Intake Information (Adolescent Form)**

Date:_____________

| Full Name | Date of Birth |
|---|---|
| Address | City/State/Zip |
| Parent Name(s) | Parent(s) Preferred Contact Number |
| Email | Parent(s) Occupation |

Referred by

Spiritual/Religious Orientation (if any)

School/Grade

| Family Physician's Name | Insurance Company |
|---|---|

Psychiatrist's Name

Name(s) of previous therapist(s) and dates seen

Names/dosages/frequency of medication adolescent is prescribed

Reason for seeking therapy