Alison Godby Ligocki, Ph.D.

New Patient Intake Information

Date:_____

Full Name	Date of Birth
Address	City/State/Zip
Email	Home Phone
Cell Phone	Work phone
Preferred Contact (Phone or Email)	Insurance Company
Referred by	Gender
Ethnic Background	Spiritual/Religious Orientation (if any)
Occupation	Employer/School
Marital Status	Spouse/Partner's Name
Family Physician's Name	Psychiatrist's Name

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

Names/dosages/frequency of medication you are taking

Emergency Contact (Name, Relationship, and Phone Number):

Please briefly describe the concerns that bring you here: