DrCynthiaSmith.com (949) 565-5015

Client Intake Form

Name: ______________________________

Address: ______________________________
____
____

Home Phone: ______________________________

Other Phone: ______________________________

Occupation: ______________________________

D.O.B. ___/___/___ Age: ____ Date: ___/___/___

Gender: _______ Height: ______ Weight: _______

Race/Ethnicity: ___________ Marital Status: _____

DL #: ______________________________________

Email: _____________________________________

Current Living Arrangements (people living with you):

Name	Age	Relationship

Date of last physical exam: _______________ Current Doctor: _____________________________________
Phone#: ______________________

Current medical conditions: ____
____

Current medications: ____

Significant prior medical conditions: ____
____
____

Prior mental health treatment: ____
____
____

Current reason for seeking treatment: ____
____
____