

# Kathy Doyle MSW LCSW

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## INTAKE INFORMATION

Client Name: \_\_\_\_\_

Client Address: \_\_\_\_\_

\_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Gender: \_\_\_\_\_

Client Phone: Primary \_\_\_\_\_ May I leave a message? \_\_\_\_\_

Alternate \_\_\_\_\_ May I leave a message? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Have you had prior treatment? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, Where? \_\_\_\_\_ With Whom? \_\_\_\_\_

For How Long? \_\_\_\_\_ Primary Issues \_\_\_\_\_

How were you referred? \_\_\_\_\_

Reason for seeking therapy at this time \_\_\_\_\_

\_\_\_\_\_

Any previous diagnosis: \_\_\_\_\_

Please list all psychotropic medications prescribed (list additional information on back of page):

Medication	Dosage	Frequency
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