In touch therapy
FOR THE MIND & BODY

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Psychotherapy/Physical Therapy
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Intake Form

Name:____ Phone:____

Date of birth/age:______________________________ Home address:____________________________________

Others living with you:___________________________ ____

____ Payment information on file:

Emergency contact:______________________________ Credit card #_____________________________________

Email:____ CVV(code)#_______Exp date_______Zip code__________

Reasons for therapy:		
Present medical condition(s):	Past medical history:	
Other Information:		
Student/occupation:	Exercise:	Interest/hobbies:
Present level of activity:		
Previous therapy:	Previous craniosacral therapy/ hypnotherapy:	
Have you ever considered or attempted suicide (if yes, when/how):		
Have you ever been hospitalized (if yes, when/where):		
Medications/what for:	Prescribed by whom:	Phone: