MARIA SCHMID, Registered Psychologist # 3415
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INTAKE REGISTRATION FORM

Today's Date:_____

Your Name(s):_____

Address(es)/Postal Code:_____

Email(s): _____

Home Phone: (____)_____message ok?___(y or n?) Cell Phone: (____)_____message ok?___
Work Phone: (____)_____message ok?___

Date(s) of Birth: _____

Emergency Contact Name: _____ Phone:(____)_____ Relation: _____

How did you find out about Maria?_____if web what site?_____

May I have your permission to thank this person for the referral?___(y or n?)

Have you seen a counsellor before? (y or n?)____ What made it meaningful?_____
_____

What are you looking for now?_____
_____
_____

I believe that the best care is provided when health care practitioners are aware of one another. With your written consent below, I would like to send your physician or other health care practitioners a pamphlet from my office. In no way would they know you are seeking counselling with me. In taking your confidentiality seriously I will always ask you to sign a separate consent should I ever need to speak directly with anyone about you.

Dr. Name(s): _____

Phone: (____)_____ and/or Address:_____

Other Health Care Practitioners *(Psychiatrist, Specialists, Naturopath, Dentist, Chiropractor, etc.)*:

Dr. Name(s): _____

Phone: (____)_____ and/or Address:_____

Thank you.