SHELBY HARRIS, PSYD, PC
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INTAKE FORM

DEMOGRAPHICS

Name _____
(First) (Middle) (Last)

Home Address _____
(Street)

_____
(City) (State) (Apt/Suite) (Zip)

Telephone: (Home) _____ (Work) _____

(Cell) _____ Occupation: _____

Date of Birth _____ E-mail Address _____

EMERGENCY CONTACT

_____
(Name) (Relationship to you)

Telephone: (Home) _____ (Cell) _____

Does this person know that you are seeing a psychologist? YES ☐ NO ☐

REFERRAL SOURCE

___Doctor Name: _____
___Friend/Relative Name: _____
___Website Specify: _____
___Other Specify: _____

AUTHORIZATION TO **RECEIVE** AND **RELEASE** INFORMATION FROM PRIMARY CARE PHYSICIAN, PSYCHIATRIST AND ANY OTHER RELEVANT TREATMENT PROVIDERS

SHELBY HARRIS, PSYD, PC

DATE: _____

I, _____, authorize Dr. Shelby Harris to discuss my information and treatment (includes any pertinent psychological and medical background information and current issues) with the following parties:

1. Name: _____Affiliation: _____

Address:_____

Phone Number:_____

2. Name: _____Affiliation: _____

Address:_____

Phone Number:_____

3. Name: _____Affiliation: _____

Address:_____

Phone Number:_____

I understand this authorization will expire at the end of treatment or at any time prior upon written request.

I hereby consent that this communication can take place through (check all that apply):

_____*telephone* _____*fax* _____*email* _____*mail*

Date: _____

Name of Patient (Print): _____

Signature of Patient: _____

(if necessary) Authorized Representative's Relation to Patient:

_____