Dr. Claudia Salazar
& associates

Claudia Salazar, Psy.D

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Intake Form

Patient Information

Name_____

Address_____

City_____ State _____ Zip _____

Cell Phone_____ Home Phone_____

e-mail:_____

_____Check here if you are interested in receiving information about interesting articles, newsletters, events, and offerings related to my practice.

Date of Birth_____/_____/_____

Gender: __Male ___Female

Status: __ Single __ Married __ Divorced __Separated __Widowed ___Domestic Partnership

Primary Care Physician:_____

Who referred you to our office?_____

Occupation_____

Employer/School _____

How did you hear about me? _____

In Case of Emergency

Name of Local Friend or Relative:_____

Relationship to Patient:_____

Home Phone Number: _____

Work Phone Number:_____

Please list the 2 main problems that you would like help with in therapy

_____
_____
_____
_____

What is motivating you to seek therapy now (rather than earlier or later)

_____
_____
_____
_____

Do you have any serious or chronic medical condition? If yes, please specify:

_____
_____

List any medications you are currently taking:

_____
_____

Have you ever received any type of psychological or psychiatric services? If yes, please list provider's name, reason for treatment, reason for termination and length of treatment.

_____
_____

Please list your goals for therapy:

_____
_____
_____

Thank you!

Please bring this form to your intake appointment.