

Catherine Anne Walsh, Ph.D., P.A.

LICENSED CLINICAL PSYCHOLOGIST

INTAKE FORM

Date: _____ Referred by: _____

Name: _____ M ___ F ___

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work/Cell Phone(s) _____

Date of Birth: _____ Age: _____ SS#: _____

(Complete this section for a child)

School: _____ Grade: _____ Special Education? _____

Parent(s) Name(s): _____

Home Phone: _____ Work/Cell# _____ Place of Employment: _____

Parent's Name (if does not live with child): _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work/Cell# _____ Place of Employment: _____

Child Relationship to Parents: Natural: _____ Adopted: _____ Foster: _____

Insurance Information: _____

Referral Question/Issue: _____

Previous psychological/psychiatric services: _____

SERVICES FOR:

Children,
Adolescents,
Adults & Families

Marital &
Couples' Issues

Depression &
Anxiety Issues

Behavioral &
Family Issues

WHAT NEXT?

NEXT PHASE
OF LIFE
RETIREMENT
COACHING:

Evaluation

Individual
Adjustment

Marital &
Couples' Coaching

Shifting Gears