Text

Description automatically generated

New Patient Enrollment

Elizabeth A. Patton- Licensed Therapist

First Name ­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Number \_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height \_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_

Emergency Contact Information:

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_

Are you currently taking any medications: Yes \_\_\_\_ No\_\_\_\_

If yes, please list all medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are you being seen for today?

Counseling \_\_\_\_\_\_\_ Recovery \_\_\_\_\_\_\_\_ Consultation \_\_\_\_\_\_