

Intake Information

Joan L. Moreau, M.D.

Patient's Name _____ Date of Birth _____

Who referred you to me? _____

Who lives with you (or your child if your child is the one I am seeing)? Please give their names, ages and relationship to you.

Please list the top three problems you or your child is experiencing.

Please identify the two most important goals for us to accomplish today.

Please circle answer:

Has there ever been a suicide attempt:	Yes	No
Are there suicidal thoughts or feelings now?	Yes	No
Are there any dangerous situations or circumstances?	Yes	No

My signature signifies that the information I provided above is correct and current. My signature also indicates that I received a form on confidentiality issues and that I am aware that some third party payors require personal data in order to pay the fees for the doctor's visits. I also understand that I am ultimately personally financially responsible for the fees for the visits. I am also aware that should I cancel or miss scheduled sessions without giving 24 hours notice, I will be billed for the session directly at the discretion of the doctor.

Signature of patient or parent/guardian: _____ Date: _____