CREATIVE DEPTH PSYCHOTHERAPY

Seja Rachael MA, LPCS 1310 South First Street #200 Austin, TX 78704

* First name: _____ * Last name: _____ Date of first visit: _____

* Age: _____ * Date of birth: _____

* Address: _____

Address 2: _____

City: _____ State: _____ Zip code: _____

* Primary Phone: _____ * Leave a message?: Yes ◉ No ○

Alternate phone: _____ Leave a message?: Yes ○ No ○

* Email: _____ * May we email you?: Yes ○ No ○

Referred by: _____

Employer: _____ * Occupation: _____

Psychiatirist's name: First name: _____ Last name: _____

Psychiatirist's address: _____

Address 2: _____

City: _____ State: _____ Zip code: _____

Current medications: _____

Taken for: _____

* Pertinent health information:

_____

* In case of emergency notify: First name: _____ Last name: _____

Relationship to you: _____ Emergency Contact Phone Number: _____

* Please describe what prompted you to make this appointment?

_____

What have you tried to address your concerns?

_____

* Your form submission, below indicates that you have read, understood, and agree to abide by the Privacy Policy and agree to the conditions mentioned on the Fees & Policies page:

Yes ○ No ○

Signature: _____ Date: _____