CBT solutions of long island

1919 Middle Country Road, Suite 308
Centereach, NY 11720

New Patient Intake Form

Patient Name_____ D.O.B._____ Age _____ Sex M F

Address_____ City _____ State_____ Zip_____

Home Phone: _____Cell: _____ Work: _____

Email: _____ Ok to Email? Yes/No

Occupation_____ Marital Status S M D/Sep

Person to Contact
in Case of Emergency _____ Phone# _____ Relationship_____

Please Complete If Patient Is A Minor

Mothers Name _____ Age_____ Occupation_____ Marital Status S, M, D/sep

Home Phone _____ Work _____ Cell _____

Address _____ City _____ State _____ Zip_____
(If different from above)

Father's Name _____ Age_____ Occupation_____ Marital Status S, M, D/sep

Home Phone _____ Work _____ Cell _____

Address _____ City _____ State _____ Zip_____
(If different from above)

Who Referred You _____ Ok to Contact? Yes/No

Primary Care Doctor/Pediatrician _____ Ok to Contact? Yes/No

Date of Last Visit/Physical Exam _____