PATIENT INFORMATION

For Virginia Terhaar, Ph.D.

Name ____ Birthdate___________

Mail Address____

City__________________________________State__________Zip________________

Phone (days) ___________________________ (evenings) ________________________

Occupation____

Employer____

Emergency contact_______________________________Phone___________________

Relationship ____

Physician name__________________________________ Phone____________________

Current medications ____

____

(continue on back if needed)

Previous (or current) therapist ____

Referral source ____