Candace Young, PhD – Couples Intake Form

NAME	NAME
WHO REFERRED YOU TO ME?	WHO REFERRED YOU TO ME?
DATE OF BIRTH AGE MARITAL STATUS ☐M ☐S ☐D ☐W ☐P SEX ☐M ☐F SOCIAL SECURITY #	DATE OF BIRTH AGE MARITAL STATUS ☐M ☐S ☐D ☐W ☐P SEX ☐M ☐F SOCIAL SECURITY #
HOME ADDRESS CITY, STATE, ZIP CODE E-MAIL ADDRESS EMPLOYER OCCUPATION	HOME ADDRESS CITY, STATE, ZIP CODE E-MAIL ADDRESS EMPLOYER OCCUPATION
HOME PHONE MAY WE CALL ? Yes ☐ No ☐ LEAVE A MESSAGE ? Yes ☐ No ☐ WORK PHONE MAY WE CALL ? Yes ☐ No ☐ LEAVE A MESSAGE ? Yes ☐ No ☐ CELL PHONE MAY WE CALL ? Yes ☐ No ☐ LEAVE A MESSAGE ? Yes ☐ No ☐	HOME PHONE MAY WE CALL ? Yes ☐ No ☐ LEAVE A MESSAGE ? Yes ☐ No ☐ WORK PHONE MAY WE CALL ? Yes ☐ No ☐ LEAVE A MESSAGE ? Yes ☐ No ☐ CELL PHONE MAY WE CALL ? Yes ☐ No ☐ LEAVE A MESSAGE ? Yes ☐ No ☐
If someone other than you is responsible for paying your bill, please provide the information in this section and have that person sign this form. NAME RELATIONSHIP TO YOU ADDRESS IF DIFFERENT CITY, STATE, ZIP HOME PHONE EMPLOYER WORK PHONE	If someone other than you is responsible for paying your bill, please provide the information in this section and have that person sign this form. NAME RELATIONSHIP TO YOU ADDRESS IF DIFFERENT CITY, STATE, ZIP HOME PHONE EMPLOYER WORK PHONE
OTHERS LIVING IN YOUR HOME NAME BIRTHDATE RELATIONSHIP TO YOU	OTHERS LIVING IN YOUR HOME NAME BIRTHDATE RELATIONSHIP TO YOU
EMERGENCY CONTACT NAME PHONE RELATIONSHIP TO YOU	EMERGENCY CONTACT NAME PHONE RELATIONSHIP TO YOU
❒ I understand that health insurance plans do not cover couples therapy. ❒ I understand that payment in full is due at each visit. RESPONSIBLE PARTY'S SIGNATURE DATE	❒ I understand that health insurance plans do not cover couples therapy. ❒ I understand that payment in full is due at each visit. RESPONSIBLE PARTY'S SIGNATURE DATE