Peggy J. Wynne, MFT

INDIVIDUAL + COUPLES COUNSELING

NEW PATIENT INTAKE

Name: _____

Male☐ Female☐ Date of Birth:_____

Address: _____

City :_____ Zip Code:_____

Mobile:_____ Email: _____

Marital Status: Married☐ Divorced☐ Single☐ Separated☐

Living w/partner☐ Widow/er☐

Name of Spouse or Partner: _____

Referred by:_____

Have you been in therapy before? Yes☐ No☐

Are you currently under the care of a physician? If so, for what:

List all medications: (prescribed or over- the- counter):

_____

_____

Alcohol or non-prescribed drugs: (amount and frequency):

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465 California St., Suite 630 San Francisco, Ca 94104 TEL 415.777.1940 peggy@peggywynne.com

Have you ever been evaluated or treated for chemical dependency, depression, anxiety, eating disorders, or other behavioral or mental health issues? If so, please describe:

What are your current goals for therapy?

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