Emily Cavell, PhD

CLINICAL PSYCHOLOGIST

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Please take a few moments to complete the following information. All information will be kept strictly confidential.

Name: ____

Date of Birth: ____________________ **(mm/dd/yy)**

Address: ____

____

____

Email: ____

May I email you? Y N

Work Phone:____

Home Phone:____

Cell Phone: ____

(Please indicate preferred contact number)

Emergency Contact: ________________________________ **Relationship:**______________

Phone: ____

Primary Care Physician: ______________________________

Phone:____

Other Treatment Provider:______________________________

Phone:____

Referred by:____

Have you been in therapy before? Y N

With Whom:____**Phone:**__________________

May I contact these providers to discuss your care? Y N

If yes, please sign and date:

x____ **Date:**__________________