Kimberly Yost, LCPC, JD

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INTAKE INFORMATION

Please Print

Name _____

First Middle Last

Preferred _____

Address _____

City _____ State _____

Zip _____

Phone _____

Email _____

Date of Birth _____ Age _____

Emergency Contact _____

Relationship to contact _____

Phone _____

Name of personal physician _____

Address _____

Phone _____

Date of last physical exam _____

Any current health issues?

_____

_____

_____

Current medication	Reason for taking
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Any significant past health issues?

_____

_____

_____

Have you ever been hospitalized? Y / N

If so, where, when, and for what reason?

_____

_____

_____

How did you hear about me? _____

_____

As a professional courtesy, may I send a note to thank them for the referral? Y/N

**This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.*