David K. Cox, Ph.D.
Therapy With Direction

TherapyWithDirection.com
2830 NW 41st Street, Suite D-4
Gainesville, FL 32606
(352) 378-3000

INTAKE FORM

DATE (mm/dd/yy): _____

Client Name: _____ _____
(Last Name) (First Name)

Date of Birth: _____ Person(s) Responsible for Payment: _____

Address: _____

City: _____ State / Zip Code: _____

Phone Number: _____ Work Phone Number: _____

Please Check:

	Ethnicity:	Marital Status:	Education Level:
☐ Male	☐ African American	☐ Never Married	☐ Elementary School
☐ Female	☐ Asian	☐ Married (How long _____)	☐ Middle School
	☐ Hispanic	☐ Separated	☐ High School
	☐ White	☐ Divorced (How long _____)	☐ College
	☐ Other : _____	☐ Widowed	☐ Graduate School

Place of Employment / School: _____ # of Years / Grade: _____

Why have you come here today?

_____

_____

_____

Do you take any medications? _____ If Yes, medication name & frequency: _____

_____

_____

Have you had previous therapy? _____ If Yes, when & was the experience positive? _____

_____

_____

Hobbies (List up to 3): _____

_____

_____

Referred By: _____