Jeff Strnad, LMFT, SEP

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Patient Information (Confidential)

Name: _____ Date: _____

Date of Birth: _____

Phone Numbers:

H: _____ May I contact you at this number? Yes ___ No ____

M: _____ May I contact you at this number? Yes ___ No ____

W: _____ May I contact you at this number? Yes ___ No ____

Email: _____ May I contact you via email Yes ___ No ____
** Note: Email correspondence is not considered to be a confidential medium of communication.

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Care Physician: _____ Phone Number: _____

Current Medications:
_____
_____
_____

Significant Medical History and Health Problems:
_____
_____
_____
_____

Primary issues for which you would like help:
_____
_____
_____
_____

How were you referred to my office? _____

Whom may I thank for referring you? _____

Emergency Contact Information: _____