Caren Baruch-Feldman, Ph.D.
Licensed Psychologist
65 Ernest Drive
Scarsdale, NY, 10583
914-646-9030

# INTAKE FORM

Today's Date ____/____/_____ Date of Birth ____/___/____

Name_____

Address_____

City_____State_____Zip_____

Home # ( )_____ Work # ( )_____

Cell # ( )_____ Fax # ( )_____

Email _____

***(IF PATIENT IS A CHILD):***

*Mother's Name*_____*Work # ( )*_____

*Father's Name*_____*Work # ( )*_____

*School*_____ *Telephone#( )*_____

Emergency Contact_____Relationship _____

Home # ( )_____Cell # ( )_____

Referred By_____

***EDUCATIONAL HISTORY:***

**(IF PATIENT IS A CHILD)**

Pre-school_____Elementary_____

High School_____College_____

Other_____

**(IF PATIENT IS AN ADULT)**

High School_____College_____

Graduate School_____

Other_____

***MEDICAL STATUS***

Physician_____

Address_____

Are you currently taking any medications? _____

If so, please list:

_____

_____

***TREATMENT HISTORY***

Are you or have you ever been in psychotherapy? ___Yes ___No

Dates_____

Name of therapist_____

Telephone number_____

Have you ever had a psychological/neuropsychological testing?

___Yes ___No

If so, Date_____ Tested by_____

Additional

Information_____

_____