## Wholistic Therapeutic Services, LLC

Alexia M. Tanner, LCSW P.O. Box 1743 Tifton, GA 31794 229-396-4689 and 229-396-4605 (Fax) www.wtstifton.com

## New Patient Intake Form

			Date
First Name	_ Middle Initial	Last Nam	e
Address			
City	State		Zip Code
Leave Messages on: (Circle one) Home Phone ()			Don't leave messages
Cell Phone ()	Ema	nil	
<b>Date of Birth</b> /	_	Sex:	☐ Male ☐ Female
Parent or Guardian:			SSN: (optional)
Insurance:	Policy Number		Group ID
Secondary Insurance:	Policy Number		Group ID
Brief History of Symptoms:			
Referral Source and #: Will the referral source contact the Office Use Only:	ne client with the ap	pointment ti	me? Yes/No (circle one)
Date Received:			Office:
Appointment:	Status	of Contact (	Who and When):
Reason for Hold:			
Therapist Assigned:			
Other Information:			