

Demographic Sheet

Name: _____ Date of Birth: _____

Gender: Male _____ Female _____ Transgender Male / FTM _____
Transgender Female / MTF _____ Genderqueer / Both man and woman /
Neither man nor woman _____ Prefer Not to Answer _____

Address: _____

OK to receive mail? Y ___ N ___

Phone Number(s):

Home: () _____ OK to Call? ___ Y ___ N OK to leave message? ___ Y ___ N

Cell: () _____ OK to Call? ___ Y ___ N OK to leave message? ___ Y ___ N

Work: () _____ OK to Call? ___ Y ___ N OK to leave message? ___ Y ___ N

Emergency Contact Information:

Name: _____ Address: _____

Phone: H () _____ W () _____ Relationship: _____

Mental Health Contact Information: (if applicable)

Psychiatrist: _____ Phone: () _____

Signed Release of Information: Y ___ N ___

General Physician: _____ Phone: () _____

Signed Release of Information: Y ___ N ___

Other Professional: _____ Phone: () _____

Signed Release of Information: Y ___ N ___

Student Therapist (print): _____ Fee for Services: \$ _____

Therapist's Supervisor (print): _____ Intake Date: _____