CAITLIN SHEPHERD, PH.D.
Licensed Clinical Psychologist

24 S. Prospect St., Suite #104
Amherst, MA 01002
www.caitlinshepherdphd.com

Phone: (413) 345-6607
Fax: (413) 858-7653
Email: caitlinshepherdphd@gmail.com

DEMOGRAPHIC INFORMATION

Name _____ Intake Date _____/_____/_____

Date of Birth _____/_____/_____ Age _____ Gender _____

Social Security Number _____-_____-_____ Relationship Status _____

Street Address _____ City/State/Zip _____

Primary Phone (_____) _____-_____ OK to leave message? ___ Text? ___

Secondary Phone (_____) _____-_____ OK to leave message? ___ Text? ___

Email _____ OK to contact via email? _____

Preferred method(s) of contact: ____ Phone ____ Text ____ Email

Ethnic/Racial Identity _____ Sexual Orientation _____

Occupation _____ Employer/School _____

Spiritual Orientation _____ Referred by _____

TREATMENT INFORMATION

Please briefly indicate what you would like to address in therapy: _____

_____

_____

_____

If you have other current healthcare or psychiatric providers, please indicate:

_____ _____
Primary Care Physician Last Physical Exam

_____ _____
Address Phone Fax

_____ _____
Psychiatrist Dates of Service

_____ _____
Address Phone Fax

_____	_____
Other Agency/Provider	Dates of Service
_____	_____
Address	Phone Fax

If you are currently taking medication, please indicate the medications, dosages, and prescriber:

_____	_____	_____
Medication	Dosage	Prescriber
_____	_____	_____
Medication	Dosage	Prescriber
_____	_____	_____
Medication	Dosage	Prescriber

If you have participated in therapy in the past, please indicate with whom, when, and for what:

_____	_____	_____
Agency/Provider	Dates	Issues
_____	_____	_____
Agency/Provider	Dates	Issues
_____	_____	_____
Agency/Provider	Dates	Issues

EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____

Street Address _____ City/State/Zip _____

Primary Phone (_____) _____-_____ OK to leave message? _____

Secondary Phone (_____) _____-_____ OK to leave message? _____