Client Intake Form
Sherry L. Osadchey, MA, LMFT, SEP
CT License #565

Date :

Name

Preferred Pronouns

Street, City, State, Zip

Partner/Spouse

DOB

Place of Employment

Telephone (Home)

Cell

Email

Number Preferred for Private Messages

Name & Number To Call In Emergency

Medical/ Physical Problems

Current Medications

Past or Present Psychotherapy No

Therapist(s) current

Previous

Past/Present Addictions

PLEASE NOTE MY CANCELLATION POLICY. THERE WILL BE A FULL FEE CHARGE FOR ANY MISSED, CANCELED OR RESCHEDULED APPOINTMENTS MADE AFTER 6 PM OF THE EVENING BEFORE AN APPOINTMENT.

Signature