Daniel L Richards PhD.,LCPC,NCC
1321 Washington Ave
Suite 102
Portland, Me 04103
207-712-0497
dan@drdanrichards.com

INFORMATION FORM

Date_____

First Name_____ Last Name_____
Address_____City_____State_____Zip_____
Birthdate_____Age_____
Home Phone_____Work Phone_____
Cell Phone:_____E-mail_____

Employed by_____
Insurance Company_____ID #_____
Group #_____Social Security #_____

Partner's Name_____ Last Name_____
Marital Status_____ Birthday_____Age_____
Cell Phone_____Work Phone_____
E-mail_____

Referral Source: A friend_____Physician_____Therapist_____Other____

Medications currently taking:
Name_____Amount_____Date started_____
Name_____Amount_____Date started_____
Name_____Amount_____Date started_____

Other medical information you feel I should know about you_____
_____
Current Physician_____Location_____
Other therapists previously or currently seen _____
_____

PLEASE NOTE:
Clients pay at each session. I charge the full fee for same day cancellations or for "NO SHOWS". (Exceptions are made for severe weather and illness)Please give us 24-hour notice if you must cancel a session. My answering line is available 24 hours, 7 days a week. Thank you for your consideration in this matter.

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