

Susan Sugar, LCSW
Certified EMDR Therapist

Intake Information

Name _____ Date _____

Address _____ City _____, AZ Zip _____

Social Security # (if needed) _____ Birthdate _____

For each number given below - I give permission: To call Leave a message

	Yes	No	Yes	No	Initial
Home Phone _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Work Phone _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cell Phone _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Email _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Marital status: NM/S M D Sep W

Education: HS ____ Some college ____ Tech school ____ College grad ____ Post grad ____

Occupation _____ Employer _____

Emergency contact _____ Phone _____

Current medical conditions: _____

Current medications/ psych meds: _____

Primary Physician _____ Phone _____

Psychiatrist _____ Phone _____

Insurance company _____ Phone _____

Insurance ID _____ Group/ID # _____

How did you hear about me? Who referred you? _____

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