**Leslie R. Goehl, Ph.D.**

Licensed Clinical Psychologist

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**Client Intake Form**

Date:

Name:

Date of Birth:

Address:

Parent/Guardian/Significant other name(s):

Email:

Home phone:

Cell phone:

Permission to contact/leave message:

 Text: Yes\_\_\_\_\_ No\_\_\_\_\_

 Email: Yes\_\_\_\_\_ No\_\_\_\_\_

 Phone: Yes\_\_\_\_\_ No\_\_\_\_\_

Primary Care Doctor: Phone:

Partner/Marital Status:

Occupational Status/Position:

Referred by:

*Optional:*

*Preferred pronouns:*

*Gender:*