***R. Phillip Colon, Ph.D.*** ***Clinical Psychologist***

**Initial Consultation Form**

Date:

Name:

Address (including Zip Code):

Home Tel #: Mobile Tel #:

E-mail address:

Date of Birth: Age:

Occupation:

Have you previously been involved in psychotherapy?

( ) No ( ) Yes
If yes, please give the approximate dates of treatment and where provided.

When did you last receive a comprehensive physical exam?
(Provide approximate month/year)

Have you ever been diagnosed as having a physical disorder requiring special medical attention?

( ) No ( ) Yes If Yes, please specify (e.g. Diabetes, hypertension, cancer, etc:

Please list medications you are currently taking: