

Dr. Kurt Moore, Ph.D., LPC

Dr. Hell & Back, Ltd.

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Intake Form

NAME: _____

GENDER: _____ DATE: _____

ADDRESS: _____

D.O.B.: _____ Age: _____

TELEPHONE: Home: _____ OK to leave a message? Yes ___ No ___

Mobile: _____ OK to leave a message? Yes ___ No ___

REFERRAL BY: _____

PERSON AND TEL. # TO CALL IN EMERGENCY: _____

REASONS YOU ARE INTERESTED IN WORKING WITH ME?

PAST/PRESENT MEDICAL CARE (Specify: major problems, accidents, hospitalizations, current medication): _____
