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Name: _____

DOB: _____

Phone Numbers:

H: _____ May I contact you at this number? Yes _____ No _____

M: _____ May I contact you at this number? Yes _____ No _____

W: _____ May I contact you at this number? Yes _____ No _____

Email: _____ May I contact you via email? Yes _____ No _____

** n.b. Email correspondence is not considered to be a confidential medium of communication.

Address: _____

City: _____ State: _____ Zip Code: _____

Current Medications:

Significant Medical History and Health Problems:

Primary issues with which you would like help:

How were you referred to my office? _____

Whom may be thanked for referring you? _____

Emergency Contact Information: _____