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Therapists Name	Today's Date
Full Name	Date of Birth
Street Address	Social Security #
City and State	Home Phone
Zip Code	Cell Phone
County	Email Address

Client Information

Personal Information

Gender	Marital Status
Employment	Reason for Seeking treatment

Parent or Legal Guardian

Name	Phone
Address	Relationship to Client

Emergency Contact Information

Name	Home Phone
Relationship to Client	Cell Phone

Health Care Information

Name of Primary Care Physician	Name of Clinic
Address	Phone

Name of person or business that referred you to us _____