



*Dr. Rachelle R. Mand, Ph.D.*

**PATIENT INFORMATION**

Name: \_\_\_\_\_ D.O.B \_\_\_\_\_ Age: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Marital Status (circle one): Married Single Divorced Separated How Long: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name of Employer: \_\_\_\_\_ How Long: \_\_\_\_\_ Phone #: \_\_\_\_\_

Occupation: \_\_\_\_\_ How Long: \_\_\_\_\_

Email Address: \_\_\_\_\_ Driver's License Number: \_\_\_\_\_

Referred by: \_\_\_\_\_ Phone #: \_\_\_\_\_

Family Physician's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

List of Medications You Are Taking (if any): \_\_\_\_\_

\_\_\_\_\_

Previous Psychological/Psychiatric Counseling: \_\_\_\_\_

\_\_\_\_\_

Please take a moment and explain the problem(s) for which you would like to have counseling

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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**SPOUSE'S INFORMATION:**

Name: \_\_\_\_\_ D.O.B \_\_\_\_\_ Age: \_\_\_\_\_

Employer: \_\_\_\_\_ How Long: \_\_\_\_\_

Work Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ How Long: \_\_\_\_\_

**IF THE PATIENT IS A MINOR:**

Child's Name: \_\_\_\_\_ D.O.B \_\_\_\_\_ Age: \_\_\_\_\_

Name of School: \_\_\_\_\_ Grade: \_\_\_\_\_

List of Medications You Are Taking (if any): \_\_\_\_\_

\_\_\_\_\_

Please identify behaviors you are concerned about: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**INSURANCE INFORMATION:**

If you would like to get reimbursed by your insurance company, please fill out the following:

Name of Insurance Company & Address: \_\_\_\_\_

Subscriber's Name, DOB, & Address: \_\_\_\_\_

Counseling sessions are about 50 minutes and they are confidential. Payment is due at the end of each session. Telephone consultations will be charged time proportional. Cancellations must be phoned in at least 24 hours prior to the session; otherwise you will be charged for the time reserved for you.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_