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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_____

24586 Hawthorne Blvd., Suite 109, Torrance, CA 90505
Phone/Fax 310-375-2100 • www.DrMandPhd.com • Rachelle@DrMandPhd.com
MFT: 15445

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: _____

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