

Bonnie Rose, M.A., L.M.F.T.

License #32633

www.BonnieRose.com

Client Information

Name _____ Today's Date _____

Social Security No. _____ Birthdate _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ May We Leave A Message? Yes ___ No ___

Work Phone _____ May We Leave A Message? Yes ___ No ___

Mobile Phone _____ May We Leave A Message? Yes ___ No ___

Email Address _____ May We Email You? Yes ___ No ___

Please note: Email correspondence is not considered to be a confidential medium of communication

Insurance Co _____

Policy No _____ Group No _____

Subscriber Name _____ Birthdate _____

Employer _____ Relationship to Patient: Self ___ Spouse ___ Child ___

Ins Co Phone _____ Co Pay Amt On Insurance Card _____

Name of Emergency Contact _____

Best Phone Number _____ Relationship _____

Please provide any information that you want me to know about your health history.

What is your main concern (s) that brings you to therapy?

SUBSTANCE USE HISTORY:

Have you ever abused drugs or alcohol?

If yes, please describe: Substances Amount Frequency When? (First use; Last use)

Substances	Amount	Frequency	When? (First use; Last use)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If yes, have you ever received substance abuse treatment of any kind before? Y__N__

Do you have a history of blackouts, seizures or withdrawal symptoms? Y__N__

Employer / School: _____ *Job Title:* _____

Marital Status: *Never Married* _____ *Domestic Partnership* _____
Married _____ *Separated* _____ *Divorced* _____ *Widowed* _____

<i>Name of Family Members</i>	<i>Age</i>	<i>Relationship to Client</i>	<i>Living at Home (Y or N)</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please describe anything else you would like me to know:

Are you fearful of or allergic to : Dogs? Yes__No__ Cats? Yes__No__

Name & Phone No of the Person Who Referred You

I, _____, hereby give permission to Bonnie Rose to contact the person who referred me, for the sole purpose of thanking them for their referral. I acknowledge that this person will know I am receiving psychotherapy services from Bonnie Rose.

Signature _____ *Date* _____