Brooke Bralove
PSYCHOTHERAPY

Patient Information Sheet

Name: _____

Pronouns: _____

Home Address: _____

Home Phone: _____ OK to leave message? Yes No

Work Phone: _____ OK to leave message? Yes No

Cell Phone: _____ OK to leave message or text? Yes No

Email: _____

Date of Birth: _____

Marital Status: _____

Will you be submitting for insurance reimbursement? _____

Are you currently employed? Yes No Where? _____

Medical Conditions: _____

Current Medications: _____

Prescribing Physician: _____

Have you ever been in therapy before? If so, when and with whom? _____

_____

Does anyone in your family have a history of mental illness? If so, who? _____

_____

How were you referred to me? _____

Emergency Contact (Name, Relationship, and Phone): _____