Mary Bermani, LMFT
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1370 Brea Blvd
Fullerton CA 92835
(562) 760-7645
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Date _____

Referred By: _____

PATIENT REGISTRATION - INTAKE

COUPLE INFORMATION

Name _____

Address _____

City _____

State _____ Zip _____

Mobil Phone _____

Residence Phone _____

Business Phone _____

O.K. to leave messages ( ) Yes ( ) No

Date of Birth _____ Age _____

email _____

Name _____

Address _____

City _____

State _____ Zip _____

Mobil Phone _____

Residence Phone _____

Business Phone _____

O.K. to leave messages ( ) Yes ( ) No

Date of Birth _____ Age _____

email _____

Marital Status: Single ( ) Married () Separated ( )

Children's Names and Ages:

	Name	Date of Birth	Age	Grade
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

LEGAL GUARDIAN OF MINOR(S) _____

If child does not live with both biological parents, where does other parent reside?

Name _____

MEDICAL INFORMATION:

Date of last physical exam _____ _____

Please list any current medical problems _____

_____

Please list all medications you are currently taking _____

_____

Please list all previous psychiatric care and medications taken _____

_____

PSYCHOLOGICAL DATA

Previous Counseling/Therapy ( ) Yes ( ) No

Name of Previous Counselor or Therapist _____

Address _____ Phone _____

_____

City State Zip

Please give a brief statement of current problems and reasons you are seeking counseling at the present time _____

_____

_____

_____

_____

Person Responsible for this Account? Name: _____

Address _____

Phone _____

Employer _____

Address _____

Phone _____

Dated _____ By _____

Patient or Other Authorized Person

Please check all of the following which you may currently be experiencing, or have experienced in the past:

Names		Names	
	Heart Trouble		Cancer
	Shortness of Breath		Frequent or severe headaches
	Pain or pressure in chest		Epilepsy episodes or convulsions
	High Blood Pressure		Tics
	Dizziness or fainting		Stroke
	Diabetes		Head Injury
	Fatigue		Back Problems
	Lack of Energy		Kidney/Bladder Problems
	Loss of pleasure in daily activities		Bed wetting or soiling
	Unusual bleeding		Hepatitis, jaundice or liver problems
	Asthma		Allergies _____
	Hives		Rash
	Pregnancy		Drug/Alcohol Dependence/Abuse
	Forgetfulness/memory problems		Anger/Irritability
	Dissociative Episodes		Anxiety or Nervousness
	Difficulty Sleeping		Loss or Increase in appetite
	Other serious illness? Specify _____		