EMILY ROSTEN, MSW, Ph.D., Licensed Psychologist

Date:_____

Name:_____

Address:_____Zipcode_____

Phone Numbers: Home _____ Work_____

Social Security # _____ Age _____ Date of Birth_____

Employer_____Occupation (major if student)_____
Work Address_____
Person to Contact in Case of Emergency_____
Address_____
Phone_____ Relationship_____

Health Insurance Company___
Address_____
Phone _____ Policy # _____ Group #_____

Physical/Emotional Concerns (X if problem, ? if possible problem or you are unsure)

_____ Heart Problems
_____ High blood Pressure
_____ Gastro-Intestinal (Stomach) Problems
_____ Respiratory (Breathing) Problems
_____ Sleep Problems
_____ Eating Problem/Concern
_____ Headaches
_____ Drug/Alcohol Problem
_____ Other Health Problem (explain)
_____

_____ Stress
_____ Anxiety
_____ Depression
_____ Mood Swings
_____ Suicidal Feelings
_____ Past Suicide Attempt(s)
_____ Grief/Loss
_____ Sexual Abuse/Incest
_____ Other (explain)
_____

Do You Use Alcohol? Yes No
If Yes, How Much and How Often_____

Do You Use **Non** Prescription Medications or Illegal Drugs? Yes No
If Yes, What type and How Often_____
If taking prescription medication, what type(s) and what for? _____

Have You Ever Had Counseling Before Yes No
If Yes, In what situation?_____
Name and Address Of Counselor_____

Appointment and Payment Policies

Sessions are **50 minutes** in length.
Payment or insurance co-payment is due at time of session.
If unable to keep a scheduled appointment **you must call to cancel 48 hours in advance**, without this cancellation you are still responsible for payment in full. **Most insurance companies will not pay for missed/appointments.**
Your signature shows that you agree with these terms and also represents your consent for release of information from me to your insurance company for billing/payment purposes.

Client_____ Date _____

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