Cheryl S. Rubenstein, PhD, LLC
Psychologist

104-A Annapolis Street
Annapolis, MD 21401

301-461-1717

Mr. Mrs. Ms. Dr. _____ Sex M F

Soc. Sec. # _____ DOB _____

Telephone (H) _____ (W) _____ Cell _____

Address _____

_____

E-Mail Address _____

Date of Birth _____ Place of Birth _____

Marital Status ____ Single ____ Married ____Separated ____Divorced ____Widow(er) Previous Marriages? Y N

Children/Siblings (Please provide names and birth dates)

_____ _____ _____

_____ _____ _____

Spouse/Significant Other _____

Education _____ Degree/Years completed _____

Employer _____ Position _____

How long with employer? _____

Who referred you to us? _____

Reason for referral _____

Please describe the problem(s) for which you are seeking help.

_____

_____

Emergency Contact

Name: _____ Relationship to you _____

Telephone (H) _____ (W) _____ (Cell) _____

Patient Name: _____

Primary Physician _____ Specialty _____

Telephone _____ Address _____

_____

Date of last physical _____ Medications _____

_____

Medical problems/conditions _____

Please provide the names and telephone numbers of other healthcare providers who are actively involved with your treatment at this time. Include Rehabilitation Nurse, Physical Therapist, and any complementary medicine providers, for example, Massage Therapist and Acupuncturist.

_____ _____

_____ _____

_____ _____

FAMILY HISTORY Please describe the presence of any medical or psychological problems, substance abuse (drugs, alcohol, food), physical and/or sexual abuse in your family of origin.

_____

_____

Any other information you believe would be important for us to know about you?

_____

_____

_____

Do you have prior experience with psychotherapy? ____ Yes ____ No.
If yes, with whom and when?

_____

_____

FINANCIAL RESPONSIBILITY FOR SERVICES (Please fill out if the financially responsible party is someone other than the patient)

Responsible Party (please print) _____ Date of Birth _____

Signature of Responsible Party _____ Social Security # _____

Address _____

_____

_____

Patient's Signature Date