RACHEL BERNSTEIN, LMFT, MS.Ed
16255 Ventura Blvd
Suite 806
Encino, CA 91436

NEW PATIENT INTAKE FORM

For new counseling clients

Patient Name

First Name

Last Name

Address

Street Address

Street Address Line 2

City

State/Province

Postal/ Zip Code

Country

Date of Birth

mm/dd/yyyy

Pronouns

They/Them, She/Hers, He/His (other)

RACHEL BERNSTEIN, LMFT, MS.Ed
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Suite 806
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Email

ex: joemoe@hotmail.com

Home Phone

Area Code — Phone Number

Cell Phone

Area Code — Phone Number

Preferred Method of Contact

Type "X" in desired box

- [ ] email
- [ ] cell phone
- [ ] home phone

Marital Status

RACHEL BERNSTEIN, LMFT, MS.Ed
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Emergency Contact Information

First Name

Last Name

Street Address

Street Address Line 2

City

State/Province

Zip Code

Country

Mobile Phone Number

Work or Home Phone Number

Relevant Medical History

Please describe any relevant medical diagnoses, treatments, and illnesses that are important for Rachel Bernstein to know. Examples include: recent hospitalizations (mental and/or physical), diagnoses such as bipolar depression, and physical illnesses that affect your mental status.

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Current Medications

Please list all current medications and dosages (ex: Zoloft, 25mg)

Do you use alcohol?

Type how many drinks you have per week, on average, in the box below

(ex: 0-6 drinks)

Is your usage something you would like to talk about? Type yes or no in the box below.

Do you use any other substances?

Please list and give a brief overview of your usage

Primary Care Provider

First Name

Last Name

Phone Number

Area Code

–

Phone Number

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Signature

Your signature certifies that all of the above information is truthful and accurate

Date (mm/dd/yyyy)

Type your full name in the box below as your signature