Toni Rabinowitz, Ph.D, LMFT
Client Information

Please Print:

Name:_____ **Date of Birth:**___/___/___

Address:_____ **City & Zip:**_____

Sex: Male__Female__

Home Phone: (_____)_____ Confidential voice message OK?_____

Work Phone: (_____)_____ Confidential voice message OK?_____

Cell Phone: (_____)_____ Confidential voice message OK?_____

Employer/ School:_____
Marital Status: Married___ Single___ Divorced___ Widowed___

Name, Age, Relationship Other Family Members:_____
_____
_____
_____
If Partner is attending: Name_____ **Date of Birth**_____

Emergency Contact:_____**Phone:** (_____)_____
Family Physician Name:_____**Phone:**(_____)_____
Address:_____ **City:**_____ **Zip:**_____
Relevant Medical Conditions (history, current status):_____
_____

Medications (dosage, name of prescribing professional):_____
_____

Previous Psychotherapy Treatment (If yes - approximate dates and name of therapist):_____
_____
_____

Referred by:_____

If Seeking Insurance Reimbursement:

Name of Insurance Company**:**_____
Phone Number of Insurance Company**:** (_____)
Insured Name**:**_____Date of Birth:_____
Insured Employer**:**_____
Policy Number**:**_____