ANNE THOMPSON, PH.D.
439 NORTH LARCHMONT BOULEVARD
LOS ANGELES, CALIFORNIA 90004
424.246.6275

PATIENT INFORMATION

Name: _____ Date: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Date of Birth: _____

Occupational Background: _____

Relationship Status: _____

Children: _____
(Name(s), gender, date of birth)

Other Persons Residing in Household: _____

Emergency Contact: _____
(Name, relationship, phone number)

Partner/Spousal Information

Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Occupation: _____

Briefly describe primary reason(s) for seeking therapy:

Treatment Modality: (circle) Individual Couple Family Pre/postnatal Group

Previous Therapy Experience: (circle) Outpatient Inpatient None

If applicable, briefly describe previous experience(s) in therapy:

Medical Information

Medication History:

Medication taken in the past: _____

Currently taking medication: _____

How many milligrams: _____

Prescribing physician: _____

To be completed by Dr. Thompson

Referrals: If applicable, reviewed with patient possible referrals for medication, other therapies, etc.

Records: (circle) Requested Patient declined Not requested

Fees: A fee of $_____ was agreed to by the patient, to be paid each session.

Therapeutic Interaction: Patient agreed to ____ psychotherapy sessions per week to address concerns related to presenting issues.

Comments:

____ Patient was informed: (1) that all matters of treatment were negotiable and fully within his or her control to accept or reject; (2) that other therapies may provide similar or better results; (3) that the therapist makes no claims about the superiority of this therapy over other available treatments.

____ Confidentiality: The limits of confidentiality were explained to the patient and the patient was invited to question any aspect of the contract for psychotherapy.