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Licensed Psychologist

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*Psychotherapy for Individuals, Couples, and Groups
Certified IMAGO Relationship Therapist
Clinical Hypnosis
Psychological Evaluation and Consultation*

PATIENT INFORMATION

Date _____

PERSONAL INFORMATION

Patient's Name _____

Home Address _____

City/State/Zipcode _____

Home Telephone (____)____-____ Work Telephone (____)____-____

Cell Phone (____)____-____ E-Mail _____

Birth Date _____ Age _____ Sex: Male Female

Social Security # _____-____-____

How did you hear about me, or who referred you to me?

Relationship Status: Single Married Partnered Separated Divorced Widowed

Employer Name and Type of Business _____

MEDICAL

Primary Care Doctor: _____ Phone (____)____-____

Currently or recently treated medical issues, and currently taken medications:

PREVIOUS THERAPY

Have you been in therapy before? Yes No When? _____

For how long? _____ Who was your therapist? _____

Have you ever been evaluated by a psychiatrist for medication? Yes No

Psychiatrist's Name _____ When _____

What was the reason? _____

Medications Prescribed: _____, _____, _____

Have you ever been hospitalized for mental health issues? Yes No

Where: _____ When/How Long _____

PROBLEMS THAT YOU ARE EXPERIENCING

Please check all that apply:

___ Depression ___ Substance Abuse ___ Eating Problems

___ Anxiety ___ Sexual Dysfunction ___ Panic Attacks

___ Post-Traumatic Stress ___ Relationship Problems ___ Medical Crisis

___ Suicidal/Homicidal Thoughts ___ Problems with Concentration, Attention, or Sleep

___ Grief/Loss ___ Adjustment to New Situation ___ Other (describe)

EMERGENCY CONTACT INFORMATION

In case of emergency who should I contact? _____

Phone Numbers: (H) _____ (W) _____ (C) _____

Contact person's relationship to Patient _____

OTHER INFORMATION

Is there any other information it would be important for me to know at this time that was not covered on this form? Please use the space below, and the other side of this page if needed.