PATIENT INTAKE SHEET

Aline P. Zoldbrod, Ph.D. Licensed Psychologist AASECT-certified sex therapist

Your Name_____D.O.B._____Status: **Sin Sep MarWid Div**
Today's date_____ Phone H:
Ph:C Ph:W
Address: Street Town Zipcode
Emergency Contact, name and phone

Referred by
Reason for therapy/goals for therapy
1
2
3
Are you here because you want to be, or because someone else wants you to be? Self yes/no Other yes/no
Prior therapy experience (name of therapist, years, good or bad experience)

Do you get regular exercise y/n Number of alcoholic drinks per week? FAMILY VIOLENCE? Yes No
Are you taking any drugs for anxiety, depression, or any other psychiatric condition?Y/N
Name and phone of prescribing psychiatrist_____

Name and town of your general MD_____
Medications you are on from your physician:
Medication names dose Medication name dose

Do I have your permission to speak with the other professionals who treat you for medical or mental health issues? Your signature_____date_____

Prior mental hospitalizations: y/n When and for what?
Any suicidal thoughts? Y/no Describe
Any other concerns or issues that I should know about?

FINANCIAL RESPONSIBILITY***: I understand that these sessions are totally outside the insurance system.No paperwork will be filed, no receipts to insurance will be issued. I also understand that I must pay for sessions if I do not cancel within 48 hours before the session. (except in emergencies. I am not cruel….)***. *If I refuse to pay, I understand that my confidentiality may be abridged if the claim is sent to a collection agency.*
Signature_____Printed name_____date_____

I understand that if Dr. Zoldbrod needs ongoing conferences with other involved therapists, I will be charged at her ongoing rate for these conferences. Signature_____ date_____

Permission for Dr. Zoldbrod to Bill charge Card for Services

Date_____

Name_____ (printed)

I hereby give Aline Zoldbrod permission to bill my charge card

$_____ for services today.

Charge card number_____ Expiration date_____

Security Code_____ Zipcode_____

Signature_____