

**RACHEL BARBANEL-FRIED, PSY.D.**

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**PATIENT INFORMATION SHEET**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Cell Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Where is the best place to leave a message? \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

**HEALTH**

Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Last Physical Exam: \_\_\_\_\_

Medications: \_\_\_\_\_

Significant Medical History (chronic conditions, accidents, major illnesses or surgeries):  
\_\_\_\_\_  
\_\_\_\_\_

**PREVIOUS PSYCHOLOGICAL TREATMENT**

Type/Length of Treatment: \_\_\_\_\_  
\_\_\_\_\_

Provider's Name and Address: \_\_\_\_\_

Have you ever been hospitalized for psychiatric reasons? If so, list dates and locations:  
\_\_\_\_\_  
\_\_\_\_\_

Who referred you to Dr. Barbanel-Fried? \_\_\_\_\_

**EDUCATION AND EMPLOYMENT**

Education: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

May I contact you at work?  Yes  No

Person Responsible for Payment (if other than self?) \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

If Patient is a minor, Legal Guardian's Name: \_\_\_\_\_

Guardian's Address and Phone Number: \_\_\_\_\_

**FAMILY INFORMATION**

List members of your family and all others in your home:

Name	Age	Relationship	Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**CURRENT CONCERNS**

Briefly describe your reasons for seeking help at this time: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_