ELIZABETH RONA L.M.F.T. S.E.P.
Licensed Individual Marriage and Family Therapist
SOMATIC EXPERIENCING® and EMDR

Patient Information

Name_____ DOB_____

Address_____

Phone Number_____ Prefered Phone Number_____

Email Address _____

Occupation/Employment Status _____

Spouse/Guardian_____

Name Phone Number

Emergency Contact_____

Name Phone Number

Primary Physician_____

Name Phone Number

How were you referred?_____

Person Financially Responsible _____

Relationship

Address_____ Phone_____

Patient/Guardian _____

Signature_____

What issues/concerns have resulted in your seeking therapy at this time?_____

_____

Goal for psychotherapy?_____

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Los Angeles, California 90049

Have you ever had the same or similar condition? ____Yes ____No

If yes, when and describe_____

_____

What attempts have you previously made to resolve this issue?_____

_____

Family history of mental health or substance abuse? ____Yes ____No If yes, who, when and describe

_____

Regular Physical Activity/Body Work_____

Diet: Good_____ Fair_____ Poor_____

Alcohol Use Yes_____ No_____ How much per week_____

Other Substance Use Yes_____ No_____ What/How Much_____

Signature_____Today's Date_____

Signature_____Today's Date_____