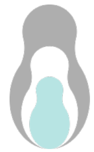

ElizabethHandy
emdr, brainspotting, crm & psychotherapy

Screening Information

THIS SHEET MUST BE FILLED IN COMPLETELY

Please Print Clearly

Date: ____/_____/________ Client's Social Security #: ______ / _____ / __________

Client's First Name: __________________ Last Name: ________________ MI: _________

Address: ____

City: ___________________________________ State:__________ Zip: ___________

Telephone (Home): __________________________ (Work): ____________________________

Email Address: _____________________________________

Birthdate: _____/_____/________ Age: _____ Gender: ________________ Race: _______________

Name of Spouse/Guardian: __________________________ Phone: ______________________

Address: _____________________ City: ______________ State: ____________ Zip: _______

Person Responsible for Payment: ____________________ Soc. Sec. #: _____ - ____ - _______

Signature of Person Responsible for Payment: ____

(Must be signed for services to begin)

EMERGENCY INFORMATION

In case of emergency, contact:

Name (1): _________________ Relationship: __________ Phone: __________ Work: ________

Address: __________________ City: ________________ State: _________ Zip: ____________

Name (2): _________________ Relationship: __________ Phone: __________ Work: ________

Address: __________________ City: ________________ State: _________ Zip: ____________

Physician: ____ Phone: _____________

Address: __________________ City: ________________ State: _________ Zip: ____________

Psychiatrist: ____ Phone _______________

Address: __________________ City: ________________ State: _________ Zip: ____________

Other Physician: ___________________________________ Phone: _______________________

Current Medications: ____

Allergies: ____

How did you hear of my practice? ____

Address ____

City: _____________________________________ State:__________ Zip: ___________

Phone _________________________

Relationship to referral source _____________________________

(Revised 10/2013)

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