Dr. Rachelle R. Mand, Ph.D.

PATIENT INFORMATION

Name: ____ D.O.B _____________________ Age: _______

Home Address: ______________________________________ City: _____________________ Zip: ________

Marital Status (circle one): Married Single Divorced Separated How Long: _________ Phone #: ________________

Name of Employer: ____________________________ How Long: _________ Phone #: ________________

Occupation: __________________________________ How Long: _________

Email Address: __________________________________ Driver's License Number: ____________________

Referred by: ____ Phone #: ______________________

Family Physician's Name: ____________________________________ Phone #:______________________

List of Medications You Are Taking (if any): ____

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Previous Psychological/Psychiatric Counseling: ____

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Please take a moment and explain the problem(s) for which you would like to have counseling

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24520 Hawthorne Blvd. #220, Torrance, CA 90505
Phone 310-375-2100 Fax 310-375-0343 • www.DrMandPhd.com • Rachelle@DrMandPhd.com
MFT: 15445

SPOUSE'S INFORMATION:

Name: ____ D.O.B ____________________ Age: _______

Employer: ____ How Long: _______________________

Work Address: ____

Occupation: ____ How Long: ______________________

IF THE PATIENT IS A MINOR:

Child's Name: ____ D.O.B __________________ Age: _____

Name of School: ____ Grade: __________________

List of Medications You Are Taking (if any): ____

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Please identify behaviors you are concerned about: ____

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INSURANCE INFORMATION:

If you would like to get reimbursed by your insurance company, please fill out the following:

Name of Insurance Company & Address: ____

Subscriber's Name, DOB, & Address: ____

Counseling sessions are about 50 minutes and they are confidential. Payment is due at the end of each session. Telephone consultations will be charged time proportional. Cancellations must be phoned in at least 24 hours prior to the session; otherwise you will be charged for the time reserved for you.

SIGNATURE: ____ DATE: ________________________

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