Rachelle R. Mand, Ph.D. MFT #MC15445

24520 Hawthorne Blvd. #220
Torrance, California 90505
Phone: 310-375-2100 / Fax: 310-375-0343

Patient Information

name______________________________birth date________________age______________

home address____zip code_________

home phone____________________________social security #_______________________

marital status: mar. sgl. div. sep. how long?_____________________________________

employer____________________________________how long?_______________________

work address____

occupation___________________________________ bus. phone _____________________

educational background____

spouse's name__________________________birth date_____________ age_____________

employer____________________________________how long?________________________

work address____

occupation___________________________________bus. phone_______________________

educational background____

children's names and ages____

are you taking any medications?___________please list:____________________________

family physician:______________________________bus. phone_______________________

previous psychiatric or psychological counseling for you or any family member?

____

IF PATIENT IS A MINOR:

child's full name________________________________birth date____________age_______

name of school____grade__________________

is the child taking any medications?_______please list:_____________________________

what behaviors are you concerned about?_______________________________________

____

(by signing this form you are authorizing Dr. Mand to treat your child)

has your child had counseling before? ____

name of the therapist ____

date treatment began ____

referred by___________________________________ bus. phone_______________________

Patient Signature_________________________________date___________________________

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please take a few moments and explain the problem(s) for which you would like to have counseling:

Please note that telephone consultations are charged time proportional and cancellations must be phoned in at least 24 hours prior to the session, otherwise you will be charged for the time reserved for you. Thank you for your cooperation.

Patient's Initial_____________________