Deborah Weisberg, LMFT, LPCC

Psychotherapy

PATIENT INFORMATION FORM

CONFIDENTIAL

PERSONAL

Name: ____DOB: ____________Age: ______

Male: ____Female: ____Relationship Status:____________________________________

Phone Numbers (Home):_____________(Cell):_____________(Work):______________

Email:____

Address: ____

____

EMERGENCY

In Case of Emergency Notify: ____________________Phone #: _____________________

Primary Care Physician: ________________________Phone #: _____________________

Psychiatrist: _________________________________Phone #: _____________________

MEDICAL PROBLEMS

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MEDICATIONS PAST/PRESENT

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(310) 712-5650 822 S. Robertson Blvd Suite 303 Los Angeles, CA 90035
Licensed Marriage & Family Therapist, MFC 50800
Licensed Professional Clinical Counselor, LPCC 730

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CONFIDENTIAL PATIENT INFORMATION

Name:	**Age:**	**Birth Date:**	**Today's Date:**
Reason(s) for seeking therapy:			

Symptom & Severity (√ if applicable)	**Mild**	**Moderate**	**Severe**	**For how long?**
Depressed Mood, Hopelessness				
Social Isolation, Loneliness				
Suicidal Thoughts				
Bereavement or Feelings of Loss				
Anxiety, Frequent Worry or Tension				
Panic Attacks				
Anger, Hostility				
Violent Acts				
Obsessive Thoughts				
Strange, Unusual Thoughts				
Memory Problems				
Problems Concentrating				
Compulsive Behaviors				
Gender Dysphoria				
Sexual Problems				
Weight Fluctuations				
Sleep Problems				
Eating Problems				
Communication Problems				
Financial Problems				
Employment Difficulties				
Physical Disability				

Substance Use	**No**	**Yes**	**How often?**	**Substance Use**	**No**	**Yes**	**How often?**
Alcohol				Sedatives			
Marijuana				Opiates			
Cocaine				Hallucinogens			
Methamphetamines				Stimulants			

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