*Sarah Berger, Ph.D.*

*Licensed Clinical Psychologist*

*Capital Psychological Services, LLC*

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City & State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Best Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*By providing an email addresses I am giving Sarah Berger, Ph.D. and Capital Psychological Services (CPS), LLC permission to make contact via email. I understand that email cannot be guaranteed to be secure or error-free as information could be intercepted, corrupted, lost, destroyed, arrive late or incomplete, or contain viruses. I understand that Sarah Berger, Ph.D. and CPS, LLC do not accept liability for any errors that may arise as a result of email transmission.

Relationship Status (please circle):

Single Significant Relationship Married/Partnered

Separated Divorced Widowed

Other (please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any children (please circle): Yes No Age(s)\_\_\_\_\_\_\_\_\_\_\_\_

Please give a brief description of the problem that led to seeking therapy at this time:

Have you ever been seen by a therapist/psychiatrist? If so, please describe:

How did you learn about my practice? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do I have permission to contact this person (please circle)? Yes No

If yes, please provide contact information\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_