RAINER GEISSLER MA, LMFT (MFC 48467) - Certified Therapist in EMDR
Office: S Los Angeles Street, Los Angeles, CA - Mailing Address: P. O. Box 712067, Los Angeles, CA, 90071
Phone: 415.999.1049 - Fax: 213.266.8310 - email: emdrtherapy@rainergeisslerlmft.com

CLIENT INFORMATION FORM

Today's Date: _____

Personal Information:

_____ _____
Client's Name (or Responsible Adult) Home Phone

_____ _____ _____ _____
Date of Birth Gender Sexual Orientation Ethnicity

_____
Street Address Apartment # City State ZIP code

_____ _____ _____
Occupation Work Phone Cellular Phone

_____ _____
e-mail address Social Security Number

_____ _____
Emergency Contact Name Emergency Contact Phone

_____
Relationship to you? (Family Member / Friend)

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Is it ok to call and/or email you for scheduling purposes? Yes ❑ No ❑
Is it ok to leave a voicemail? Yes ❑ No ❑

Relationship Status:

❑ Single ❑ LAT ❑ Registered Partners ❑ Married ❑ Divorced ❑ Widowed

Referred by:

_____
Referral Source

_____
Highest Level of Education completed

Insurance Info:

_____
Name of Insurance (If no Insurance please check here for ☐ Private Pay)

_____
Member ID

_____
Group ID

I am not a Medicare Medical provider. If you are Medicare/Medical eligible or become Medicare/Medical eligible during your treatment, your initial acknowledges that you understand that Medicare/Medical will not reimburse you and you will be responsible for out of pocket payment of your sessions. **Initial here** ☛ _____

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Additional information:

1. What is your main reason(s) for seeking help at this time?

2. For how long have you had these issues/problems/symptoms and how often do they occur?

3. What steps did you take to deal with those issues/problems/symptoms so far?

4. Have you ever been in therapy in the past? If so, when? For how long?

5. Are you currently seeing a psychiatrist and/or are you taking any psychiatric medications? If so, who is the prescribing physician (name, address, phone number)

6. Have you ever been hospitalized for psychiatric reasons (5150)? If so, when, how often?

7. Have you ever had or do you currently have any thoughts of harming yourself or others? Have you ever attempted suicide in the past?

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8. Do you have any acute or chronic medical conditions, including head-injuries, heart conditions, or a history of seizures?

9. Do you have a history of drug and/or alcohol abuse/addiction? If so, what kind of drugs did you use?

   a) How frequently do you currently use alcohol and/or other drugs?

   b) Have you ever been in treatment for past or current substance abuse?

10. Is there a family history of mental health issues / psychiatric symptoms? If so, what family member and what diagnosis?

11. Do you have any current legal problems or pending court dates?

12. Is there any additional information not covered that you'd like to provide?