

# Rainer Geissler, M.A.

Licensed Marriage & Family Therapist (MFC 48467)

870 Market Street, Suite 1101 & 45 Franklin Street, Suite 319- San Francisco, CA 94102

Phone: 415.999.1049 – Fax: 415.896.4568 – email: [rainergeissler@comcast.net](mailto:rainergeissler@comcast.net)

## CLIENT INFORMATION FORM

Today's Date: \_\_\_\_\_

### Personal Information:

\_\_\_\_\_  
Client's Name (or Responsible Adult)

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Gender

\_\_\_\_\_  
Sexual Orientation

\_\_\_\_\_  
Ethnicity

\_\_\_\_\_  
Address (including 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:

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Referral Source

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Highest Level of Education completed

## Insurance Info:

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Name of Insurance

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Member ID

---

Group ID

**Additional information:** (Insurance pay only)

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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?