Client Information Sheet

The information requested on this form is completely confidential.

Today's Date: _____

PERSONAL

Name:_____

Mailing Address: _____

City:_____State:_____ Zip:_____
Telephone numbers: home_____work _____

Is it okay to leave confidential messages at the above numbers? Yes No (circle one)

Birthdate: _____Birthplace:_____

EMPLOYMENT

Employer: _____Occupation:_____
Employment address:_____

FAMILY HISTORY

Father: ___Living ___Deceased Current age or age at time of death: ____ Cause of death:

Mother: ___Living ___Deceased Current age or age at time of death: ____ Cause of death:

List birth order of your siblings, including yourself, indicating number of years between you (see example):
(Example: Older Brother -- 3 yrs. --- Older Sister --- 1 yr. --- ME --- 2 yrs. --- Younger Brother)

Family Birth Order:_____

IN CASE OF EMERGENCY,
PLEASE CONTACT:_____PHONE: _____
REFERRED TO THIS OFFICE BY: _____

Jill Solomon MA, MFT #40159
8271 Melrose Avenue, LA CA 90046
Individual, Group and Couples Psychotherapy

Please complete next page of this form too.

PSYCHOTHERAPY AND MEDICATION HISTORY

Have you ever sought psychotherapy or counseling before? Yes No (circle one)

If so, when? _____For how long? _____

Please list all medications you are currently using: _____ _____

_____

Apart from those medications listed above, have you ever used any of the following:

Anti-depressants	Yes	No (circle one)	Anti-anxiety meds	Yes	No
Appetite suppressants	Yes	No	Laxatives	Yes	No
Sedatives	Yes	No	Muscle relaxants	Yes	No
Pain medication	Yes	No			

FEES AND INSURANCE

Payment by check or cash is requested at the beginning of each individual or couples session, and at the first session of each month for group sessions. For checks returned for insufficient fees, a service charge of $25.00 is assessed.

Those patients who wish to utilize health insurance benefits will be provided with a statement reflecting service provided and payments made. This statement should be submitted directly to the insurance company for reimbursement, attached to a claim form. Since your insurance policy is a contract between you and your insurer, you are advised to understand its provisions. As the insured, you are entitled to an explanation if your insurer rejects your claim for any reason. Rejection of your claim does not, however, relieve you of your obligation to pay for services provided.

Do you require a monthly statement to seek insurance reimbursement? Yes No (circle one)

CANCELLATION POLICY

To avoid being charged for a cancelled session, the session must be cancelled at least 48 hours in advance by leaving a message at (323) 692-3759. Sessions cancelled with less than 48 hours notice will be charged at the full fee. By law, insurance providers may not reimburse patients for fees paid for cancelled sessions.

POLICY AND LAWS REGARDING CONFIDENTIALITY

All information between patient and therapist is held in strict confidence. The only exception to this is that state law requires all mental health providers to report suspected child or elder abuse, and allows for breach of confidentiality if patients disclose a likelihood to be of danger to themselves or others.

I have read the foregoing and my signature below attests to my understanding of these policies.

_____

Signature **Date**