Patricia Stryd

Licensed Marriage and Family Therapist
4500 Thornton Ave. • Fremont, CA 94536 • (510) 797-9322

PATIENT INFORMATION

Date _____ Soc. Sec. # _____

Name_____
Last Name First Name Initial

Address_____

City _____State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail _____

Age _____ Birth date _____ ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Patient Employed By _____ Occupation _____

Whom may we thank for referring you? _____ Emergency Contact_____

MEDICAL HISTORY

Primary Care Physician _____ Phone_____

Addres_____ Last Visit _____

Current Medications and Dosages_____

_____

Please indicate the PRIMARY problem that has led you to seek help: ☐Depressed Mood ☐Anxiety or worry ☐Grief or loss ☐Relationship/family problems ☐Occupational problems ☐Substance use problems ☐General stress ☐Physical health problems ☐Other emotional/psychological problems

Are you concerned about your use of drugs? ☐Yes ☐No Alcohol? ☐Yes ☐No

Have you had prior mental health treatment? ☐Yes ☐No

If yes, when: _____

Do you now have a serious and/or chronic medical condition such as diabetes, cancer, heart disease, asthma, or rheumatoid arthritis? ☐Yes ☐No

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Patricia Stryd, LMFT, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Patricia Stryd, LMFT to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date