



ARTHUR ROSENTHAL MFT

Therapy for Individuals, Couples + Families in Sonoma County, CA

CLIENT INFORMATION

Name: _____ Date: _____

Home Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Age: _____ Birth Date: _____

Occupation: _____ Employer or School: _____

Emergency Contact Name: _____ Phone: _____

Relationship Status: _____ Name/Age of Partner: _____

Names/Ages of Parents: _____

Names/ages of Siblings

Names/ages of Children

Why did you decide to get therapy? _____

Previous Therapy -- Please list approximate dates and reasons for seeking therapy:

Medical Information - Please list medical conditions, illnesses, surgeries, hospitalizations, accidents, injuries, etc:

Current Medications: _____

Primary Care Physician: _____ Phone: _____ Date of last Physical: _____

Other Physician or Psychiatrist: _____ Phone: _____

