MARK E. OAKLEY, Ph.D.
CENTER FOR COGNITIVE THERAPY
4195 Chino Hills Parkway
Suite E-62
Chino Hills, CA 91709
Phone: (310) 738-6302

PATIENT INFORMATION FORM

Full Name: _____

Date of Birth: _____ Marital Status: _____

Social Security Number: _____

Home Address: _____

Home Telephone: _____ Cellphone: _____

Education (in years): _____ Degree: _____

Parents' Name (if minor): _____

Occupation: _____

Current Position: _____ How Long: _____

Employed by: _____

Work Address: _____

Work Telephone: _____ FAX: _____

IN CASE OF EMERGENCY NOTIFY:

Name: _____

Relationship: _____

Address: _____

Phone: Day: _____ Evening: _____

Your cooperation in completing this form will be helpful in planning your services for you. Please answer each item carefully and completely. All information on this form is confidential and will not be released without your prior written approval.

BRIEFLY DESCRIBE YOUR REASONS FOR SEEKING HELP:

_____

_____

_____

_____

_____

HAVE YOU EVER SEEN A PSYCHOTHERAPIST OR COUNSELOR OF ANY TYPE BEFORE? What were the reasons and outcome:

_____

_____

_____

_____

_____

DESCRIBE ANY MAJOR CHANGES IN YOUR LIFE IN THE PAST TWO YEARS:

_____

_____

_____

_____

_____

List ALL medications you are now taking – prescriptions (including birth control pills) and nonprescription (such as aspirin, allergy medication, etc.)

MEDICATION	**DOSAGE (amount & times per day)**	**REASON**

Physician: _____

Telephone: _____

Alcohol Intake (please describe average intake):

_____

_____

List the people currently living in your home:

NAME	**AGE**	**RELATIONSHIP**	**OCCUPATION**

It is customary courtesy of our office to send a thank you note to the doctor or person who referred you for this consultation. Please indicate whether or not that is acceptable and, it if is, to whom the letter should be sent.

You have my permission to send a letter of thanks (Please initial) _____

Please do not send a thank you note (Please initial) _____

Address: _____

Telephone: _____

Is it OK to send mail to your home address? ❑ YES ❑ NO

Thank you for providing this information. Full payment is expected at the time services are rendered unless other arrangements are made. If cancellation is not made 24 hours in advance, you may be charged full session fees.

I HEREBY GUARANTEE PAYMENT FOR SERVICES TO THE CENTER FOR COGNITIVE THERAPY:

_____ _____

Signature of responsible party Date

I HAVE BEEN GIVEN A COPY OF THE CALIFORNIA NOTICE FORM REGARDING PRIVACY

Please initial: _____ Date: _____