Gia Vajrini Buonaguro, MFT
PSYCHOTHERAPY • EMDR • FLOWER ESSENCES ASTROLOGY

Patient Intake Form:

Name____ Date__________________

Age _______ Birth Date _____________

BirthTime (if known)______________________

Birth Place______________ Cell Phone (__) ______________

Email________________

Work Phone (___) ____________ Home Phone (___)_________________

Address_________________________________ City, Zip _______________

Occupation ____________________________ Name of Firm _____________________

Work Address ____

In case of emergency, please notify: ____

Phone: ____

Relation to you: ____

YOUR PHYSICIAN:

Name _______________________________________ Specialty ___________________

Address _____________________________ Phone (___)_________________

Last physical: Year ___________ Doctor _____________________ City _____________

Please describe your current medical condition ______________________________

giabmft.com • 310 386 7838 • gbmft@mac.com • MFT License 47777

CURRENT MEDICATIONS:

Name of Drug | Dosage | Purpose

____

____

________________________ ______________ ___________________

________________________ ______________ ___________________

HOSPITALIZATONS, ACCIDENTS, SURGERIES:

Year | Event | Outcome

___________ ________________ ________________________

___________ ________________ ________________________ __

BEGINNING TREATMENT:

Who referred you to this office? ____________________________________

Relationship ____

PATIENT'S SIGNATURE: I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS. I ALSO AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PROVIDER FOR SERVICES RENDERED. INSURANCE COMPANY WILL BE BILLED AS COURTESY. PATIENT IS LIABLE FOR PAYMENT OF ALL BEHAVIORAL HEALTH SERVICES RENDERED.

Patient Signature: _______________________________ Date:

Patient Signature: _______________________________ Date: