

Joshua M. Cohen, Ph.D., LLC

Jackson Place
966 Hungerford Dr., #32A
Rockville, MD 20850

Office (301) 315-6301
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NEW PATIENT INFORMATION

Date _____

PERSONAL INFORMATION

Patient's Last Name _____ First Name _____

Home Address _____

City _____ State _____ Zip Code _____

Home Telephone _____ Work Telephone _____

Cell Telephone _____ E-Mail _____

Birth Date _____ Age _____ Sex: Male Female

Social Security # _____ How did you hear about this office - Dr. Cohen?

Relationship Status: Single Married Partnered Separated Divorced Widowed

Employer Name: _____

Employer Address: _____

PREVIOUS THERAPY

Have you been in therapy before? Yes No When? _____

Who was your previous therapist? _____ How long were you in therapy? _____

Have you ever been evaluated by a psychiatrist for medication? Yes No

Psychiatrist's Name? _____ When? _____

What was the reason? _____

Medications Prescribed: _____

Have you ever been hospitalized for mental health issues? Yes No

Where: _____ When? _____

For how long? _____

MEDICAL

Primary Care Doctor: _____ Doctor's Phone: _____

Address: _____

PRIMARY COMPLAINTS AT THIS TIME

Please check **all** that apply:

- | | | |
|--|--|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Eating Problems |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Sexual Dysfunction | <input type="checkbox"/> Panic Attacks |
| <input type="checkbox"/> Post-Traumatic Stress | <input type="checkbox"/> Relationship Problems | <input type="checkbox"/> Medical Crisis |
| <input type="checkbox"/> Grief/Loss | <input type="checkbox"/> Adjustment to New Situation | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Suicidal/Homicidal Thoughts | <input type="checkbox"/> Tic Disorder | <input type="checkbox"/> Other |

INSURANCE INFORMATION

Please complete **all** information that relates to your insurance company.

Insurance Co.: _____ Card Holder's Name: _____

Patient Name: _____ Patient's SS #: _____

Patient's DOB #: _____ Member #: _____

Insurance ID #: _____ Group #: _____

Other information on your insurance card: _____

EMERGENCY CONTACT INFORMATION

In case of emergency who should I contact? _____

Contact Person's Phone Numbers: (H) _____ (W) _____

Contact person's relationship to Patient _____

If you use an Internet email service such as Yahoo or Hotmail, save the form and return it manually to JoshuaMCohenPhD@Verizon.Net using your Internet email service.