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Confidential Client Information

Date: _____

Name: _____ Age: _____ Date of Birth: _____

Address: _____

City: _____ Zip Code: _____

Home Phone: _____ Work: _____

Cell: _____ Email: _____

May I leave a message on any of your phone lines? Y N

If so, which line(s)? _____

Employer name and address:

Job title: _____

Marital Status: _____ Name of Spouse/Partner: _____

Children: Y N How many? _____

Who referred you? _____

May I notify that person that you have contacted me? Yes No

Regular Physician (Name & Phone):

Will you sign a Release of Information should a conversation/consultation become necessary? Y N

Date of last physical exam: _____

Emergency contact:

Name _____ Phone: _____ Relationship: _____

Insurance Information: _____

Social Security #: _____