Rhythm of Peace Therapeutic Services

Personal Information Form

First Name :_________________________ Last Name :__________________________

Home Address:____

City: _______________________ State:____________________ Zip:______________

Home Phone:____________________ Mobile Number:_________________________

Email Address:____

Best Method of Contact (please check one): Text____ Phone Call____ Email_____

Gender (Please check one): Male Female Other

MA# (REQUIRED):__________________________________

Reason for therapy:

____

____

____

____

____

Which service(s) are you interested in?

Home based therapy_____ Teletherapy _______ Office Based Therapy _______

Community Based Therapy_______

(WE ARE CURRENTLY ONLY OFFERING TELETHERAPY DUE TO COVID 19)

Session Frequency:

Weekly ______ Bi-Weekly________ Monthly________ As needed________

Have you seen a therapist in the past (please check one): Yes No

Do you have a mental health diagnosis? (Please list):____

____

Are you currently taking any medication? (Please check one): Yes   No

Have you child been hospitalized in the last 30 days due to mental health concerns: (Circle One): Yes   No

Emergency Contact:

First Name: ______________________ Last Name:_________________________

Contact Number:___________________________