Rhythm of Peace Therapeutic Services

New Consumer Personal Information Form

First Name :_____ Last Name :_____

DOB (Month/Date/Year):_____

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 ____

Marital Status:_____

If Consumer is a child, please list:
Legal Guardians's Name:_____ Contact #:_____

Is Consumer in Foster Care: ____Yes _____No

Medical Assistance (MA)# (REQUIRED; if you don't know you MA#, please provide your SSN#):_____ MCO:_____

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)

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_____
If yes, please list:_____
_____

Have you been hospitalized in the last 30 days due to mental health concerns:: Yes____ No____

Emergency Contact:
First Name: _____ Last Name:_____
Phone Number:_____ Relationship:_____

Please email a copy of your photo ID/Drivers License to humanservices@therhythmofpeace.com.