David F. Venarde, Psy.D., P.C.
105 West 86th Street, #108
New York, NY 10014
917.848.6964
NYS License #014368

Today's Date: _____

Name: _____

Address: _____

_____

Telephone (cell): _____

Telephone (home): _____

Telephone (other): _____

Email: _____

Date of birth: _____ Age: _____

Emergency Contact

Name: _____

Telephone: _____

Relationship to patient: _____

Please turn over & complete reverse side

___

History of Treatment

Are you currently in psychotherapy? Yes/No

Therapist's name: _____

Names and dates of previous therapists:

Name: _____ Dates: _____

Name: _____ Dates: _____

Name: _____ Dates: _____

Are you currently taking any prescription medication? Yes/No

Name of prescribing M.D.: _____

Medication(s) and Dose(s): _____

_____

Prior psychiatric medications, including names, dosages, and dates taken:

_____

_____

_____

Have you ever been hospitalized for psychiatric reasons? Yes/No

If yes, hospital(s), dates, reasons for admission to hospital:

_____

_____

Signature: _____ Date: _____