

# Patricia Stryd

Licensed Marriage and Family Therapist  
4500 Thornton Ave. • Fremont, CA 94536 • (510) 797-9322

## PATIENT INFORMATION

Date \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Name \_\_\_\_\_  
Last Name First Name Initial  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
E-mail \_\_\_\_\_  
Age \_\_\_\_\_ Birth date \_\_\_\_\_ Single Married Widowed Separated Divorced  
Patient Employed By \_\_\_\_\_ Occupation \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_ Emergency Contact \_\_\_\_\_

## MEDICAL HISTORY

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ Last Visit \_\_\_\_\_  
Current Medications and Dosages \_\_\_\_\_  
\_\_\_\_\_

Please indicate the PRIMARY problem that has led you to seek help: Depressed Mood Anxiety or worry Grief or loss  
Relationship/family problems Occupational problems Substance use problems General stress Physical health  
problems Other emotional/psychological problems

Are you concerned about your use of drugs? Yes No Alcohol? Yes No

Have you had prior mental health treatment? Yes No

If yes, when: \_\_\_\_\_

Do you now have a serious and/or chronic medical condition such as diabetes, cancer, heart disease, asthma, or rheumatoid arthritis?  
Yes No

## ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_  
and assign directly to Patricia Stryd, LMFT, all insurance benefits, if any, otherwise payable to me for services rendered. I understand  
that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Patricia Stryd, LMFT to release  
all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date