**ELIZABETH D. WINKLER, M.A., L.M.F.T.**
MFC 44979
324 S. Beverly Drive, Suite 923
Beverly Hills, CA 90212
(310)463-2444

## I. CLIENTS INFORMATION

Client: _____ Date of Birth: __ / __ / __

Address: _____

City: _____ State: _____ Zip: _____

Cellular Telephone: (____) _____ Home Telephone: (____) _____

Sex: ☐ Male ☐ Female S.S. #: _____-_____-_____

Legal Guardian: _____ Telephone #:_____

Employer/School: _____ Telephone #: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated
☐ Widowed ☐ Live with partner

**Insurance**:

Name of Insured: _____

Insured's Date of Birth: ___ / ___ / ___

Insurance Name and Plan: _____

Insured S.S. #: _____ - ____ - _____ Insured's ID #_____

Insured Group #_____

Relationship to the Insured_____

Other Insurance Plan_____

**Emergency Contact**:

Name: _____

Relationship: _____

Phone: _____

**II. MEDICAL HISTORY**

1. Health Problems ☐ No ☐ Yes If yes, briefly describe _____

_____

_____

2. Medications (dosage, dates of initial prescriptions, name of prescribing professional):

_____

_____

3. Allergies/adverse reactions to treatment:

_____

_____

4. History of Suicidal/ Homicidal Behavior: ☐ No ☐ Yes If yes, briefly describe

_____

_____

5. Substance Use History(Hx) ☐ No ☐ Yes Trauma Hx ☐ No ☐ Yes If yes, to any, briefly describe:_____

_____

Psychiatrist Name: _____Telephone: _____

Address:_____

City_____ State: ____ Zip:_____

Client Signature_____ Date _____

Therapist Signature_____ Date _____