Virginia Crist, Ph. D., LMFT
Licensed Marriage and Family Therapist
Lic. # MT 001168
1515 N. Federal Highway, Suite 300
Boca Raton, FL 33432
(561) 212 6855

I welcome you to my practice.

Name _____ Date _____

Address _____ City _____ State _____ Zip Code _____

Email _____

Date of Birth _____ Age _____ Social Security _____

Home Phone _____ Work Phone _____ Cell _____

Can you be called at your place of employment? ☐ Yes ☐ No

Check where I can call or leave a message? ☐ Home ☐ Work ☐ Cell

Occupation _____

Education (highest grade completed): _____ Religion: _____

Please Check: ☐ Single ☐ Married ☐ Remarried ☐ Separated ☐ Widowed ☐ Divorced ☐ Significant Other

Does your spouse know you are attending therapy? ☐ Yes ☐ No

Spouse's Name _____ Date of Birth _____ Number of years (re)married _____

Occupation _____ Work Phone _____

Children's Names (If stepchild, place an **X** to the left of their name)	Date of Birth	Age	Grade (If in school)
___			
___			
___			
___			
___			

Referred by: _____

May we thank your referral source? ☐ Yes ☐ No

Name of Family Physician _____ Number of Family Physician _____

May I consult with your medical doctor so that he/she is fully informed and so that we may coordinate treatment? ☐ Yes ☐ No

Current Medications: _____

Have you ever received psychological, psychiatric, drug, or alcohol treatment or counseling services? ☐ Yes ☐ No

Which treatment have you sought? _____

Name of doctor and facility providing previous mental health services	Date(s)

Do you use alcohol or drugs daily? ☐ Yes ☐ No

Has anyone criticized your alcohol or drug use? ☐ Yes ☐ No

Do you smoke or chew tobacco? ☐ Yes ☐ No

Which drugs (not prescribed medications) have you used in the last 10 years?

Please specify your presenting problem? _____

Office Policy

1)	The service fee is payable at the time of each visit. At that time, you will receive a receipt, which may be attached to your health insurance form for reimbursement. It is your responsibility to submit your claim to you insurance company.
2)	IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT, IT IS YOUR RESPONSIBILITY TO NOTIFY DR. CRIST 24 HOURS IN ADVANCE. OTHERWISE FULL CHARGE WILL BE EXPECTED FOR THE TIME YOU RESERVED.
3)	Payment is due in full at the time services are rendered. Cash or check made payable to Virginia Crist, Ph. D. is kindly accepted.

By signing below, I agree that I have read and understood this form.

Patient Signature _____ Date _____

THIS IS A STRICTLY CONFIDENTIAL PATIENT MEDICAL FORM