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Your cooperation in completing this form is helpful in planning services for you.
Please answer each question carefully and completely. All information on this form
is confidential and will not be released without your prior written consent.

Name _____
Tel. # _____

Date of Birth: _____ Marital Status _____
SS# _____

Credit Card Info: (please circle) MC Visa Discovery AmX Other _____
Number: _____ Exp: _____

Please Note Credit Card will only be charged for missed appointments and/or
unless otherwise specified by you.

Home
Address: _____

Parents Names (if minor) _____
Education: _____

Occupation: _____
Employer: _____

Current Position: _____ For how
long? _____

Work Address: _____
Phone# _____

Please describe your reasons for seeking help:

Have you ever seen a Psychologist, Psychiatrist, or Counselor before? What were the reasons? Outcome?

Please describe the major changes in your life over the past two years.

Please list all medications you are now taking, including prescription and non-prescription drugs.

Medicine	Dosage
Reason	Date Started (approx.)

Physician _____

Address _____

Phone # _____

Please list any health problems you are experiencing _____

Please describe your alcohol and drug use: _____

Do you exercise regularly? If Yes, please specify: _____

Please circle any of the following areas in which you are having difficulty:

Nervousness Depression Fears
Shyness Sexual Problems Suicidal Thoughts
Divorce Boredom Finances
Drug Use Alcohol Use Friends
Anger Self-Control Unhappiness
Sleep Problems Stress Work
Relaxation Headaches Dating Skills
Legal Matters Memory Assertiveness
Low Energy Chronic Pain Making Decisions
Loneliness Self-Esteem Concentration
Education Career Choices Performance Anxiety
Health Problems Nightmares Marital Conflict
Relationship Difficulties Parenting Problems Eating Disorder
Irritability Sudden Mood Changes Confusion
Thinking Problems Family Conflict Social Anxiety

Please Add Any Information which you feel would be helpful to your treatment.

Please list the people currently living in your home:

Name
Relationship

Age
Occupation

Please note below the person to notify in case of emergency:

Name _____

Relationship _____

Address _____

Phone (daytime) _____

Evening _____

How did you learn about The Cognitive Therapy
Institute _____

Who referred you to the
Institute? _____

May we write them a letter thanking them for the
referral? _____ (initials) _____

Signature _____
Date _____