Mark G. Brown, EdD, MA, LMHC
Psychotherapist
Individuals, Couples, Families
(206) 459-7993

Please Print

Date_____

Name_____ Phone_____(H)

_____(C)

Address_____

	Name	DOB	Name	DOB
Who is in your household?	_____	_____	_____	_____
(Include yourself)	_____	_____	_____	_____

Which family members, if any, have a history of alcohol or drug use?

_____

Which family members, if any, have a history of any psychiatric hospitalizations?

_____

Have you seen a therapist before? _____ If so, from _____ to

_____

Name of previous therapist/psychiatrist

_____

Medical History

Personal Physician_____ Phone_____ Last Seen_____

Medications:____None ____Yes (If yes, list those taken in last 6 months)

_____

Physical Illness (Circle) When Physical Illness When Physical Illness When

Allergies_____ Cancer/Tumors_____ Serious Injury_____

Head Injury_____ Diabetes_____ Heart Problems_____

High Blood Pressure_____ Dizziness/Fainting_____
Surgery_____
Gland Problems_____ Convulsions/Seizures_____
Other_____
Describe allergies/illness indicated above:_____

_____

_____

AUTHORIZATION FOR TREATMENT

I hereby request and authorize Mark G. Brown to evaluate, treat, and/or provide consultation to me or my child, for whom I am the legal guardian. I certify that, to the best of my knowledge, the foregoing information is true and complete.

I agree further to pay promptly all fees for which I am responsible. Failure to comply will result in termination of treatment. I understand that I will be billed directly for missed appointments or cancellations with less than 24 hours notice, regardless of my regular payment methods. (Insurance plans do NOT pay for missed appointments). I acknowledge that a copy of the office policy including disclosure information has been made available to me. I am aware that if I am not able to reach Mark G. Brown, I can call the Crisis Line at (509) 524-2999 for assistance.

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_____ _____ _____ _____

Client Date Witness (Therapist) Date