

DAVID A. RAUSH, PHD LLC
LICENSED PSYCHOLOGIST #3676
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STRATFORD, NJ 08084
(856) 465-5027

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Social Security #: _____

Address: _____ City: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

Relationship Status: Single Married Committed Relationship Separated
 Divorced Widowed

Education: _____ Currently Student? _____

Employment: Full-time Part-time Unemployed Homemaker Retired

Employer: _____ How Long? _____ Position? _____

Work Phone: _____ May I call you at this number? _____

Emergency Contact: Name _____ Phone _____

Physician: Name _____ Phone _____

Address _____

Referral Source: _____ Reason for referral: _____

May I contact the referral source in order to acknowledge the referral? _____

Have you previously seen a psychologist, psychiatrist, or other such professional? _____

Physical and Mental Health Problems and Medications: _____

Have you ever been arrested or had other problems with the law? _____

Are you involved in a disability, workers' compensation, or personal injury claim? _____

Please list family members and others living in your household:

Name

Age

Relationship to Patient