ERIKA L. FRANCIS-RANIERE, PH.D.

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Patient's Name: ____

First Middle Initial Last

Present Address:

Street & No.: ______________________ City: ____________ State: ____ Zip: ________

Mailing Address: *(if other than above)*

Street & No.: ______________________ City: ____________ State: ____ Zip: ________

Permission to leave or send message?

Home phone: ____________________ Y N

Work phone: ____________________ Y N

Cell phone: ____________________ Y N

Email: ____________________ Y N

Other: ____________________ Y N

Current Relational Status?

____ Single

____ Long-term partner

____ Married

____ Widowed

____ Divorced

____ Separated

How did you learn about my practice?
(Check more than one if applicable)

____ Personal referral/word of mouth
Name? ____________________

____ www.erikafrancisraniererephd.com

____ EMDR provider list (check below)

____ emdria.org

____ emdr.com

____ emdrreferrals.com

____ *Psychology Today* website

____ Other ____________________

Date of Birth: ______________________ **Age:** ______

Birthplace: ________________________________

Members of your household (including name, relationship, age): ______________________________

____

____

Emergency contact:

Name: ________________________________ Relationship: ________________

Home phone: ____________ Cell phone: ____________ Address: ______________________

Providers:

Primary Care Physician: ________________________________ Phone: ______________

Psychiatrist: ________________________________ Phone: ______________

Other Therapist or Provider: ________________________________ Phone: ______________

Last Physical Exam (month/year): __________ **Last Psychopharm Appt (if applicable):** ____________

Medical and Psychiatric Conditions: ____

____

Medications (name, dosage, frequency): ________________________________

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