Marie T. Rogers, Ph.D., PA

Licensed Psychologist

Pompano Medical & Professional Center
50 NE 26th Avenue, Suite 400
Pompano Beach, Florida 33062

Adult Intake

Full Legal Name: _____ Date: _____/_____/_____

Date of Birth: _____/ _____/ _____ Age: ____ Place of Birth: _____ Gender : _____

Address: _____

			OK to contact?	
Telephone Number:	Home	_____/ _____- _____	Yes _____	No _____
	Work	_____/ _____- _____	Yes _____	No _____
	Cellular	_____/ _____- _____	Yes _____	No _____
	Text	Same as cellular ____	Yes _____	No _____
		Only provide if different _____/_____-_____		

E-Mail address (only provide if it is OK to contact you via e-mail): _____@_____

Marital Status: _____ Children? Yes _____ No _____ If yes, how many? _____

Highest Education Completed: _____ Occupation: _____

Religious Affiliation: _____

Briefly describe why you are seeking services at this time:_____

_____

_____

_____

Estimate the severity of above problem: Mild ____ Moderate ____ Severe ___Very severe ____

Referral Source: _____

Your Physician's Name: _____ Telephone number: _____

Past/Present Medical Care (major medical problems, surgeries, accidents, etc.): _____

_____

_____

_____

Past/Present Drug/Alcohol Use/Addictions Treatment: _____

_____

Please turn page over →

General Activity Level: Active ___ Sedentary ___ Has this changed within the last 6 months? No __ Yes ___; If yes, what is the reason for the change? _____

Please list any medications you are presently taking and for what reason?

Medication	Dosage	Reason	Prescribed by?

Have you ever been treated by a mental health professional; i.e., psychiatrist, psychologist, social worker, or counselor? No ___ Yes ___ Are you presently under the care of a mental health professional? No ___ Yes ___

If you answered yes to either of the above two questions, please briefly describe when, with whom, and for what purpose: _____
_____
_____
_____

Additional Information/Comments:

In case of emergency, whom may I contact? _____
Telephone number: _____/ _____-_____ Relationship to you: _____

Payment Information

Please note that payment is expected at the time services are rendered. If you are planning on using your health insurance, then please request an invoice. It is the patient's responsibility to submit claims to his/her insurance company. Please understand that Marie T. Rogers, Ph.D., Licensed Psychologist, is not a provider with your health insurance carrier. You are therefore using out-of-network benefits when seeking the services of Dr. Marie T. Rogers.

To the best of my knowledge, the information completed on this intake is accurate. By signing this form, I understand that I am agreeing with the terms outlined above.

Name of person who completed form: _____

_____ _____
Signature Date

Telephone: 954/290-0378 E-Mail: info@drmarierogers.com Web: www.drmarierogers.com