

RACHEL BERNSTEIN, LMFT, MS.Ed

16255 Ventura Blvd

Suite 806

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Mental Health History Form



Why are you seeking treatment?

What are your expectations for therapy?

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Is there anything important for me to know in order to help you better?

Have you seen a mental health professional before?

If so, provide the information of the most relevant professional

First Name

Last Name

Area Code



Phone Number

Any additional comments

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Signature

Your signature certifies that all of the above information is truthful and accurate

Date (mm/dd/yyyy)