

ROSANNA O. ZAVARELLA, Ph.D.

24100 Chagrin Blvd., Suite 140
Beachwood, OH 44122-5545
tel: 216-321-3025

fax: 216-831-1269
email: rzavarella11@gmail.com

8338 Tyler Blvd., 2nd Floor
Mentor, OH 44060-4221
tel: 216-321-3025

New Client Information (page 1 of 5)

Please Print Clearly

Date: _____

NAME: _____ SOCIAL SECURITY #: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

EMAIL ADDRESS: _____

BIRTHDATE: _____ AGE: _____ SEX: _____ YOUR EDUCATION BACKGROUND: _____

SINGLE MARRIED WIDOWED DIVORCED HOW MANY YEARS: _____

OCCUPATION: _____ EMPLOYED BY: _____

NAMES & AGES OF CHILDREN: _____

SPOUSE NAME: _____ OCCUPATION: _____

SPOUSE EDUCATION BACKGROUND: _____ SPOUSE BIRTHDATE: _____

PRIMARY CARE PHYSICIAN: _____ REFERRED BY: _____

HAVE YOU HAD PSYCHOTHERAPY OR BEEN HOSPITALIZED FOR EMOTIONAL ISSUES? YES NO

IF YES, WITH WHOM AND WHEN: _____

DO YOU HAVE MEDICAL INSURANCE COVERING PSYCHOLOGICAL SERVICES? YES NO

DO YOU TAKE PRESCRIPTION DRUGS? YES NO IF YES, WHAT KIND AND HOW OFTEN: _____

DO YOU TAKE RECREATIONAL DRUGS? YES NO IF YES, WHAT KIND AND HOW OFTEN: _____

DO YOU DRINK ALCOHOL? YES NO IF YES, HOW OFTEN AND WHAT AMOUNT: _____

INFORMATION ABOUT OUR FEES AND CANCELLATION POLICY: Our office expects co-payments and applicable deductible payments to be made at the time of the appointment. We request a 48 hour notification if you need to cancel an appointment. Experience has taught us that with a 48 hour notice we may be able to fill that appointment hour. If you cancel with less than a 48 hour notice, you will need to pay the full fee of \$120.00 for this reserved time. All returned checks will incur a charge of \$25.00.

Your Initials: _____