

**DO NOT FILL OUT IN YOUR BROWSER.
DOWNLOAD, THEN OPEN/TYPED IN ADOBE
READER.**

This form does not guarantee an appointment. No patient-physician relationship is established by use of this form.

You may email this form (once completed, save, and send as an attachment to info@braslow.net), or fax to (415) 494-8642. If you email, note that transmission may not be secure, and may expose this info to third parties.

If you are experiencing any emergency, including suicidal or homicidal thinking, side effects to medication, or any other urgent or time-sensitive matter, do not use this form. Instead call 911 or go to your closest emergency room.

Name of person filling out this form:

Phone number:

Email address:

Referral Source:

What are your concerns?

- Anger
- Anxiety
- Attention issues
- Depression
- Mood instability
- Relationship issues
- Stress
- Substance Abuse
- Other

What kind of care is being sought?

- Psychotherapy
- Medication Management
- Both
- Unsure
- Other

Check all of the following that apply to you:

- I am in therapy now.
- I am on psychiatric medication now.
- I am having thoughts of suicide now.
- I have taken psychiatric medication previously.
- I have had thoughts of suicide recently.
- I have attempted suicide in the past.
- I have been hospitalized for psychiatric reasons.
- None of the above applies to me.

Provide more detail if you wish here:

At which office do you prefer to be seen?

- Berkeley
- San Francisco
- Either

If there is no availability at your preferred office, would you be willing to be seen at the other office?

- Yes
- No
- Maybe

I am aware that Dr. Braslow is not an in-network provider for any insurance plan and that he does not submit claims to insurance companies. However, he will provide me a statement so I may try to get out-of-network reimbursement.

- Yes
- No

So that we may focus on clinical matters, Dr. Braslow requires a valid credit card to be securely stored electronically in the patient portal. This is so that we can avoid billing problems and can focus on your clinical care. Do you consent to provide this information?

- Yes
- No