



**Rosemarie Scolaro Moser, PhD, ABN, ABPP-RP, Director**  
*American Board of Professional Neuropsychology  
 American Board of Professional Psychology-Rehabilitation  
 NJ Psychology Lic. # SI02148  
 NJ Certified School Psychologist*

**CONFIDENTIAL**  
**GENERAL PATIENT INTAKE INFORMATION**

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Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

Please Check: Female \_\_\_\_\_ Male \_\_\_\_\_ Age \_\_\_\_\_ Social Security #: \_\_\_\_\_

Home Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer or School \_\_\_\_\_

Occupation or Grade in School \_\_\_\_\_ Years of Education \_\_\_\_\_

Place of Birth \_\_\_\_\_ Religion, if applicable \_\_\_\_\_

Emergency Contact Name & Phone \_\_\_\_\_

**ADULT (Please complete this section below)**

Check One: Single \_\_\_\_\_; Married \_\_\_\_\_; Separated \_\_\_\_\_; Divorced \_\_\_\_\_; Widowed \_\_\_\_\_

Spouse's/Partner's Name & Age \_\_\_\_\_

Spouse's/Partner's Occupation \_\_\_\_\_

Childrens' Names & Ages \_\_\_\_\_

**CHILD (Please complete this section below)**

Parents' Names & Occupations \_\_\_\_\_

Sisters'/Brothers' Names & Ages \_\_\_\_\_

**Nature of Assistance you are seeking: (Please check all that apply)**

Psychotherapy/Counseling \_\_\_\_\_ Psychological Testing \_\_\_\_\_ Neuropsychological Evaluation \_\_\_\_\_

Memory Testing \_\_\_\_\_ Baseline Testing \_\_\_\_\_ Post Concussion Testing \_\_\_\_\_ Career Counseling \_\_\_\_\_

EMDR \_\_\_\_\_ Cognitive Rehabilitation \_\_\_\_\_ Hypnosis \_\_\_\_\_ Biofeedback \_\_\_\_\_

Other (explain) \_\_\_\_\_

How did you hear about this service? Who referred you? \_\_\_\_\_



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Describe the difficulties or symptoms for which you are seeking assistance.

Describe any significant past or present medical or health related conditions/surgeries/hospitalizations since birth. Are you currently receiving treatment for any of these conditions? If so, please explain:

List all your current doctors or treating health care providers:

Are you currently or have you in the past ever received any type of mental health, substance/alcohol, personal, or career counseling? If yes, when and what type of assistance have you received?

Have you ever been hospitalized for a psychiatric condition? If yes, where and when?

Has anyone in your family ever received psychological/psychiatric/mental health or alcohol/substance abuse treatment or assistance? If yes, please describe:

Have you or anyone in your family been identified as having had a learning disorder, attention disorder, or memory disorder? If yes, please describe:

Are you taking any medication? If yes, list name and dosage:

Do you use other non-prescription drugs or substances? If yes, please describe:



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Do you drink alcohol? If yes, how often?

Do you smoke? If yes, how many cigarettes per day?

I agree to accept responsibility for all payments of any services rendered to me by RSM PSYCHOLOGY CENTER, LLC/SCCNJ and its providers. I understand that payment is expected at the time services are rendered unless prior arrangements have been made. I also understand that I will be charged for any appointments that I do not cancel 24 hours prior to my scheduled appointment.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**For: Medicare, Personal Injury, Workers Comp, Victims Comp., TBI Fund, University Insurance, or other pre-arranged third party payor:**

I permit RSM PSYCHOLOGY CENTER, LLC/SCCNJ to bill the Third Party Payor for services provided.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Third Party Payor or Insurance Carrier

\_\_\_\_\_  
Address

ID/Claim # \_\_\_\_\_

Group # \_\_\_\_\_

Name of Insured/Covered Entity

\_\_\_\_\_  
Adjuster or Contact or Case Worker (if applicable)