KARIN A. MOSK, PSY.D.
ASSESSMENT AND THERAPY FOR CHILDREN, ADOLESCENTS, AND ADULTS

Dr. Karin A. Mosk, Psy.D.
620 Chesapeake Ave., #2
Annapolis, MD 21403
(410) 800-4237

BACKGROUND INFORMATION – ADULT

Date: _____

Name: _____

Date of Birth: _____ **Age:** _____ **Soc. Sec.#:** _____-_____-_____ (if using insurance)

Address:

_____

_____

Spouse's Name: _____

Address:

_____

_____

How to Contact You? **Check preferred method to reach you:**

Home Phone: _____ ☐

Cell Phone: _____ ☐

Work Phone: _____ ☐

Email Address: _____ ☐

Marital Status

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If you are separated or divorced, who has legal custody of child(ren)? _____

_____

Highest Level of Education Completed: _____

Current Occupation: _____

Physician(s):

Name: _____

Address: _____

Phone: _____

Family Members

Parents:

Mother: _____ Age: _____

Father: _____ Age: _____

Brother(s): _____ Age(s): _____

Sister(s): _____ Age(s): _____

Children:

_____ Age: _____

_____ Age: _____

_____ Age: _____

_____ Age: _____

How did you hear about this office?

☐ Friend ☐ Family Member ☐ Doctor ☐ Teacher ☐ Website ☐ Workshop ☐ Other _____

Have you ever been treated by a mental health professional?

☐ Yes ☐ No

If yes, when? _____

What was the purpose? _____

What was most helpful? _____

What was least helpful? _____

Current Concerns

Briefly describe your reasons for seeking psychological services:

_____

_____

_____

_____

_____

Brief Questions

1. What, if anything, would you change if you could? _____
2. How is your relationship with family members? _____
3. How is your relationship with peers? _____
4. What do you hope to get from this service? _____
5. What concerns, if any, do you have about it? _____

Emergency Contact

Name: _____ Phone: _____

By signing this form, I am requesting treatment with Dr. Karin Mosk and consent to all appropriate interventions and techniques.

Patient Signature: _____

Printed Name: _____

Date: _____

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CREDIT CARD AUTHORIZATION FORM

Name: _____

Email: _____

Billing Address: _____

Billing City: _____ Billing State: _____ Billing Zip: _____

Billing Phone: _____

Name on Credit Card: _____

Credit Card Type: Visa____ MC____ AmEx_____ Discover_____

Credit Card Number: _____

Credit Card AVS Code (3 or 4-digit code): _____

Credit Card Expiration Date: _____(mm/yy)

Cardholder Signature: _____

Date: _____

I authorize Dr. Karin A. Mosk, Psy.D. to charge the amount of unpaid fees, including late cancellation fees. I assume responsibility for keeping current payment methods up to date. I also agree that I will pay for this purchase in accordance with the issuing bank cardholder's agreement.