

ARIELLA ROSINGER  
P S Y C H O L O G I S T

MEDICARE PROVIDER NUMBER 4029494J

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Confidential Information

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_ Postcode: \_\_\_\_\_

**Phone:** (Home) \_\_\_\_\_ (Mobile) \_\_\_\_\_

(Work) \_\_\_\_\_ Medicare No. \_\_\_\_\_

**Email:** \_\_\_\_\_

**Emergency Contact Details:** Name \_\_\_\_\_

Tel: \_\_\_\_\_ (Relationship?) \_\_\_\_\_

Your Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Place of birth (country): \_\_\_\_\_ Religion (if any): \_\_\_\_\_

Occupation: \_\_\_\_\_ Education: \_\_\_\_\_

General Health: \_\_\_\_\_

Medications for psychological distress (if any): \_\_\_\_\_

**Family:**

**Present Status:** Single Married Living Together Divorced

Widowed Separated Other: \_\_\_\_\_

**Number of children:** \_\_\_\_\_ **Step Children:** \_\_\_\_\_

**Present dwelling:** with my family sharing with housemates alone

other: \_\_\_\_\_

**Are you Caring for:** child/ren disabled/ill/old family member/s:

**Details for current relationship-if applicable:**

Partner/Spouse's Name: \_\_\_\_\_

Partner's phone: (m) \_\_\_\_\_ (w) \_\_\_\_\_

Date of current marriage/relationship started: \_\_\_\_\_