



Dipl-Psych Karin von Rosen, MA

Licensed Psychotherapist - Certified Mindfulness & Positive Discipline Parenting Coach - Educational Psychologist

REGISTRATION FOR COUNSELLING/PSYCHOTHERAPY/DIAGNOSTICS

Parent/s' Names & Date/s of Birth:

Address:

Tel. Home / Mobile:

Email:

What is/are your present occupation/s?

Names and birthdates of children (place an * next to the child being referred):

Name/s	Birthdate	School/s	Grade

When did you come to Berlin? Where have you and your children lived during their schooling years.

Country/City	Dates: from-to	School/s	Grade/s

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Licensure: GRO 030 358 -03

SteuerNr.: 25/497/00877

IBAN: DE54 1007 0124 0011 8075 00

Deutsche Bank Berlin

Office Hours by appointment only



Have you or your child/ren had any form of counselling, psychoeducational diagnostics psychotherapy or psychiatric treatment before? Please give details (add any reports if available).

What are your main concerns at present? Please mention any symptoms or complaints.

Do any members of the family take any medication regularly?

Has anyone in the family had any serious illnesses, operations or accidents? Please give details.

Have your parents or close relatives had any serious physical or mental issues?

Please share as much as you wish about yourself and why you or your child/ren would like to access therapy at this time.

How did you hear of me?

Cancellation Policy of sessions:

In the event of my cancelling a session I understand that the full fee will be charged unless 48-hour notice is given and the fee needs to be paid before the following session can be booked.

Signed: Date: