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PATIENT INFORMATION

TODAY'S DATE ______________ **REFERRAL SOURCE** ____

NAME ____________________________________ **NICKNAME** ________________ **SSN** ______________________

DATE OF BIRTH ________________ **AGE** _______ **GENDER** ________ **ETHNICITY** ______________________

ADDRESS ____

Street *(Apartment #)* *City* *State* *Zip Code*

PHONE NUMBERS: **(Please only list phone numbers/email/fax acceptable for provider to contact you and leave message)*

Home ( ) ___________________________

Cell ( ) ___________________________

Work ( ) ___________________________

EMAIL ADDRESS: ____ **FAX NUMBER:** __________________________

MARITAL STATUS: ____Single ____Married ____Partnered ____Separated ____Divorced ____Widowed

LIVING WITH SPOUSE/PARTNER? ____Yes ____No **NUMBER OF YEARS TOGETHER** ______________________

EMPLOYER/SCHOOL _________________________________ **OCCUPATION** ___________________________________

HIGHEST LEVEL OF EDUCATION ____

CHILDREN ____Yes ____No **AGES OF CHILDREN** ____

*(Please *circle ages of children living in home)*

PRIMARY CARE PHYSICIAN ____________________________ **HOSPITAL/CLINIC** ____________________________

ADDRESS ____

PHONE NUMBER ( ) __________________________ **FAX NUMBER** ( ) __________________________

EMERGENCY CONTACT(S)

(1) NAME ____

PHONE NUMBER ( ) ________________________ **RELATIONSHIP TO PT** _________________________

(2) NAME ____

PHONE NUMBER (   ) ________________________ **RELATIONSHIP TO PT** _________________________

TYPE OF HELP DESIRED:

____Psychiatric Evaluation ____Medication management ____Individual Therapy ____Family/Couple's Counseling

1. Major reason(s) for seeking help at this time: ____

____

____

2. How long have you had these problems or symptoms? ____

____

3. How often do they occur? ____

____

4. List the people, activities, groups, and hobbies that are supportive to you/your family: __________________________

____

____

5. What are your goals for treatment? ____

____

____

6. What treatments have you tried already? ____

____

____

7. Are you currently taking any medications for medical problems (including over-the-counter and herbal)? ____Yes ____No

If yes, please list: ____

____

____

8. Do you have any serious or chronic medical conditions (including past surgeries)? ____Yes ____No

If yes, date(s) and details: ____

____

____

9. Do you have a history of serious accidents or injuries, head injury, loss of consciousness, or seizures? ____Yes ____No

If yes, date(s) and details: ____

____

10. Past and Current Psychological/Psychiatric Treatment:

(a) Counseling or Psychotherapy
   a. Therapist (MD, PhD, MFT, etc.) ____________________________
   b. Type of therapy ____________________________
   c. Dates ____________________________
   d. Helpful? ____Yes ____No

(b) Psychiatric Medications
   a. Name of Medication(s) ____________________________
   b. Prescribed by ____________________________
   c. Year(s) ____________________________
   d. Helpful? ____Yes ____No

(c) Psychiatric Hospitalization(s)
   a. Where? ____________________________
   b. Admission reason? ____________________________
   c. Year(s) ____________________________
   d. Helpful? ____Yes ____No

(d) Addiction Rehab/Treatment
   a. Where? ____________________________
   b. Admission reason? ____________________________
   c. Year(s) ____________________________
   d. Helpful? ____Yes ____No