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 that it is ok 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** ______________________

(a) ADDRESS ____

(b) PHONE NUMBER (**)** ______________________ **FAX NUMBER (** **)** ______________________

EMERGENCY CONTACT(S)

(1) NAME ______________________ **(2) NAME** ______________________

PHONE NUMBER (**)** ______________ **PHONE NUMBER (** **)** ______________

RELATIONSHIP TO PT ______________ **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:

Counseling or Psychotherapy

Yes ☐ No ☐

Therapist (MD, PhD, MFT, etc.)	*Type of therapy*	*Dates*	*Helpful (Y/N)*
1.			
2.			
3.			
4.			

Psychiatric Medications

Yes ☐ No ☐

Name of Medication?	*Prescribed by*	*Year*	*Helpful (Y/N)*
1.			
2.			
3.			
4.			

Psychiatric Hospitalizations

Yes ☐ No ☐

Where?	*Admission Reason?*	*Year*	*Helpful (Y/N)*
1.			
2.			
3.			
4.			

Addiction Rehab/ Treatment

Yes ☐ No ☐

Where?	*Admission Reason?*	*Year*	*Helpful (Y/N)*
1.			
2.			
3.			
4.			