PATIENT INFORMATION

Patient's Name: _____ **Date:** _____

◯Mr. ◯Mrs. ◯Ms. ◯Dr.

Relationship Status
◯Single ◯Married ◯Partnered
◯Widowed ◯Divorced

Birth date: _____ **Age:** _____

Sex: ☐M ☐F **Social Security No.:** _____

Address: **Email:** _____

_____ **Home Phone:** _____

_____ **Cell Phone:** _____

_____ **Work Phone:** _____

Referred by: ☐Website ☐Dr. ☐Family ☐Friend ☐Google ☐Other

Occupation: _____

Ethnic Origin: _____ **Religious Orientation:** _____

In Case of Emergency: _____ _____ _____
Name Relationship Phone Number

[Note: ***If entering information on the computer, use tab keys to access additional lines*****]**

Please state briefly why you are seeking therapy at this time, and list any symptoms or problems you wish to discuss**:**

_____

_____

_____

_____

Current Medical Problems:

_____

_____

_____

_____

Medications or Supplements you are currently taking:

_____

_____

_____

[If entering information on the computer, use tab keys to access additional lines]

Medical History: (Head injuries, Accidents, Serious Illnesses, or Hospitalizations) Dates:

_____

_____

_____

_____

Please list any mental health problems for which you were treated in the past, including:

1) What you were treated for; 2) Name(s) of providers; 3) Dates and duration of treatment:

_____

_____

_____

_____

_____

Please list any substances you currently use (alcohol, marijuana, caffeine, tobacco, opiates, psychedelics, methamphetamine, etc.) If you are in recovery, how long?

_____

_____

Psychiatric disorders and/or substance abuse in immediate or extended family:

_____

_____

_____

_____

_____

The above information is true to the best of my knowledge.

_____ _____

Patient's Signature Date

INSTRUCTIONS: Please fill out this form, print, sign and bring with you to your first appointment.