

## 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:

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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:

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

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

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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.