PLEASE COMPLETE THIS CONFIDENTIAL QUESTIONNAIRE

Date:______________

Patient Name:_____________________________Address:______________________________

City: ____________________ State:_______ Zip:_______________

Home Phone:_______________ Work Phone:_______________ Cell Phone:________________

Date of Birth:____________ Age:______ Gender:______ Marital Status:____________

Race:_____________ Ethnic Background:______________ Religion:_____________________

Occupation:______________________________ Citizenship:___________

S.S.#:________________________ Email___________________________

Closest Relative:_________________________ Relationship:_____________

Name:_________________________________

Address:____City:___________

State: _________Zip:______________ Phone:________________________

Person Responsible for Payment, if Other Than Patient:

Name:____

Address:____

City:_________________State: _________Zip:______________

Phone:___________________ Relationship:_________________________

Referring Agent:____

Permission granted for full communication with referring professional: Yes_____ No:_____

Permission to notify referring professional only that visit occurred: Yes_____ No:_____

Have you ever had any other mental health evaluation or treatment? Yes:____ No:_____

Have you ever been admitted to hospital for mental health reasons? Yes:____ No:_____

If "Yes" to either of above, List Names, Dates, and Places:

____

____

____

List any significant past or current health problems:

____

____

List any medications you are currently taking (include names, strengths, and doses):

______________________________ __________________________________

______________________________ __________________________________

______________________________ __________________________________

Medication Allergies:____

Primary Care Physician:______________________________Tel____________________

Last saw PCP Date:_________________

Amount of Alcohol Use Per Week:

____

____

Use of Other Drugs:

____

____

Do you plan to file any health insurance claims for these services? Yes:____ No:_____

If yes, statements will be provided ("Super Bill") of all charges and medical information required for you to file claims.

Payment is expected at the time of service.

Checks or cash are preferred, Credit Cards (Visa, Master Card or Discover) are also accepted.

Thank You