PATIENT INFORMATION

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Numbers: _____

Birth Date: ____/____/ ___ Driver's Lic.#: _____
State & Number

Reason for visit today:

_____

_____

_____

Referred by: _____

Age: _____ Ethnicity: _____ Job: _____

Education: _____ Grades: _____ Where were you raised? _____

Religious Affiliation (past/present): _____

Marital Status: _____ If married, for how long: _____

Describe quality of relationship: _____

Number of marriages: _____ If divorced or separated, for how long: ____

If single, describe relationships: _____

Number of children: _____ Ages: _____

Parents married: ___ Never married: _____ If divorced, how old were you? _____

Who raised you? _____ Birth order: I am the ___ child out of _____.

My childhood was (please circle one):

Very Happy Happy Typical Unhappy Very Unhappy

Is there any history of abuse? _____ If yes, please circle those that apply:

Emotional Physical Sexual

Any recent surgeries? _____

Any recent injuries, broken bones or concussions? _____

Any chronic illnesses you see a medical doctor for on a regular basis? _____

_____

Alcohol _____ (number) drinks per week ____per month or, I do not drink _____

Other substance use, past or present?_____For how long? _____

Substance(s): _____Frequency: _____

Legal issues?_____

Describe any family history of mental health problems: _____

_____

_____

Describe your overall physical health: _____

_____

Have you ever been diagnosed with a mental health problem or seen a therapist in the past? Please Describe: _____

_____

Are you feeling suicidal today? _____ In the past month? _____

List any hospitalizations in the last 5 years: _____

_____

List all medications/dosages currently being taken: _____

_____

Allergies to medications? _____

Emergency Contact:_____

Phone: _____

Any other comments: _____

_____