

Client Information

(Please print clearly and complete all pages)

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Pittsburgh, PA 15213-2851
412-682-2573

PERSONAL DATA:

Date: _____

Last Name: _____ First Name: _____ M.I. _____

Chosen Name: *(If different than first name):* _____

Address: _____ City: _____

State: _____ Zip Code: _____

Phone(s):

Home: (____) _____ May I leave a message here? Yes No

Cell: (____) _____ May I leave a message here? Yes No

May I text you at this number? Yes No

Work: (____) _____ May I leave a message here? Yes No

Email: _____ May I email you? Yes No

Date of Birth: _____ Age: _____

Relationship Status: Single Partnered Married Divorced Widowed

Student Status: Full-time Part-time Non-student

Emergency Contact: _____ Relationship: _____

Telephone # for emergency contact: _____

HEALTH DATA:

Briefly describe your reason(s) for entering into therapy at this time:

Have you ever been in treatment for mental health issues? Yes No
If 'Yes', please complete the information below:

Reason for Treatment	When (dates)	Where/who

If you are presently taking any prescribed medications, please list them here:

Medication	Dosage	Times Per Day	For Treatment of

Psychiatrist (if you have one) Name: _____ Telephone Number: _____

Do you wish to have a coordination of care letter sent to your psychiatrist? Yes No

If you answered yes, please write the name and address of your psychiatrist here:

Do you wish to have a coordination of care letter sent to your Primary Care Physician? Yes No

If you answered yes, please write the name and address of your PCP here:
