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PATIENT INFORMATION FORM - PLEASE PRINT

Today's Date: ____________

Name ____________________________________Name you Prefer to be Called____________
(Last) (First) (Middle/Maiden)

Address____
Street Apt # City State Zip code

Alt Address____
(if above not permanent) Street Apt # City State Zip code

May I send mail to your home address? *Yes / No*

Phone (H) (_____)__________________*Okay to contact? Yes/No* *Okay to leave a message? Yes/No*

Phone (W) (_____)__________________*Okay to contact? Yes/No* *Okay to leave a message? Yes/No*

Cell Phone (_____)__________________*Okay to contact? Yes/No* *Okay to leave a message? Yes/No*

Who referred you?____________________________________ *May I thank them? Yes / No*

Person to Contact in case of emergency:

Name______________________________Relationship to You__________________________

Address____

(Home)(____)______________(Cell)(____)_______________(Work)(_____)________________

Level of education completed & focus of study:____

In school now?___ Does your study satisfy you? ___ If not, please explain__________________

Occupation & Place of Employment:____

Does your present work satisfy you?______ If not, please explain__________________________

Military Service and type of discharge:____

Birthdate___/___/___ Age___ Sex: ___Ethnicity______________Sexual Orientation:________

Religious/Spiritual Preference (or anything you consider noteworthy to you about this topic)?
____

Please describe your reason(s) for seeking treatment at this time and your goals for therapy. If there is a particular event that triggered your decision to seek treatment now, please describe the event. Please attach additional paper and write as much as you need.

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How long have you been concerned about the problems that bring you to treatment now?_______

How long do you expect therapy to last?____

Do you consider the severity of your problem(s) to be: ___Mild ___Moderate ___Severe

Have you been hospitalized for a psychiatric reason? ______If yes, date(s) and outcome ________

____

Have you had any history of legal troubles, getting into physical violence, or needing court/disability evaluations? ___ If yes, date(s) and details _______________________________

____

For any mental health treatment you have received before please list:

Dates	Nature of Problem(s)/Diagnosis	Psychiatrist/Therapist/Counselor	City/State	Benefit from Therapy/Meds?

Current concerns about your medical health:____

____

Current concerns about your mental functioning (e.g., memory, confusion, suspiciousness, hallucinations):____

____

Current concerns about your sexuality (e.g., sexual orientation, sexual functioning, level of desire, safe sex practices): ____

____

Past significant medical health issues or injuries (e.g., cancer, head injury/loss of consciousness, seizures, chronic conditions): ____

____

Have you had any *one* of the following: history of DUIs, blackouts, unsuccessful attempts at cutting back on alcohol/drugs, or others expressing concern about your alcohol/drug usage?____________

Current tobacco use (type and amount): ____

Date of last physical? _________ Physician's Name________________Phone___________________

Current Medication	Dosage	Reason for Use	Helpful? Y/N	Side Effects?

Please list anyone in your family who may have a mental illness:

Relationship to You	Nature of Problem(s)	Nature of Treatment (if any)

Have any of your relatives attempted or committed suicide?_________________________________

Has anyone in your family had a history of alcohol or drug abuse?____________________________

Who lived in your household with you when you were growing up?

Name	Relationship to you	Quality of Relationship	Occupation	Current Age	Living or Deceased?

Circle any of the following that applied during your childhood/adolescence:

Happy childhood	School problems	Medical problems
Unhappy childhood	Family problems	Alcohol abuse
Legal trouble	Drug abuse	Strong religious convictions
Emotional problems	Behavioral problems	

Other:____

Current Status:__Single __Dating __Cohabitating __Engaged __Married/Partnered (# of times ____)

Relationship Loss:__Separated__Divorced__Widowed (How recent was your relationship loss? ___________)

Please list anyone living in your household now and their relationship to you:

Name	Relationship to you	Quality of Relationship	Occupation	Current Age

Partner/Spouse's Occupation:_______________________________Partner/Spouse's Age:_____

Number of Children (and ages):____

Any concerns about your current relationships?____

____

____

____

Please make any other comments here you wish (e.g., any strengths or unique qualities about you that could inform our work together, what you are looking for in a therapist, concerns about starting therapy, etc)______________________________

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Thank you for the time you put into answering this form. Hearing from you in your own words is so important.

Please print & bring this form to your first appointment.