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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	Living or Relationship to you	Quality of Relationship	Occupation	Current Age	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)_____

_____

_____

_____

_____

_____

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

Please read the Psychotherapist-Patient Services Agreement, HIPPA Notice, and Technology Notice before we meet.

Please print & bring this form and the Psychotherapist-Patient Services Agreement to your first appointment.