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Adult Information Form

Patient Name: _____ **Date**: _____
Date of Birth: _____ **Age:** _____ **Marital Status**: _____
Street Address: _____
City: _____**State** _____ **Zip Code**: _____
Home Phone: _____ **Work:** _____ **Cell Phone:** _____
Email Address: _____
Occupation: _____
Employer: _____
Work Address: _____

Partner's Name: _____ **DOB:** _____
Partner's Address: _____
_____
Phone #: Home _____ Work _____ Cell _____
Occupation/Employer: _____
Employer Address: _____

Children: YES NO Do they live with you? YES NO
Names/ Ages**:** _____
Others in the Home: _____

Who referred you to this office? _____
Why are you seeking therapy services at this time? _____
_____
Is there anyone you do not want to know you attend therapy at this office? Who and Why?:_____
Initial Goals for Treatment: _____
_____

Previous Treatment: YES NO Reason for therapy: _____
* Provider: _____ Phone #: _____
Address: _____
* Provider: _____ Phone #: _____
Address: _____
Alcohol or Substance Abuse Issues? _____
When did you first begin using drugs/alcohol? _____
Past Partial or In-Patient Hospitalizations: YES NO Why? _____
_____
Dates: _____

Current Medications: YES NO

1. Name: _____Dosage: _____When Started: _____

2. Name: _____Dosage: _____When Started: _____

3. Name: _____Dosage: _____When Started: _____

4. Name: _____Dosage: _____When Started: _____

Past Medications for Emotional/Mental Health Purposes? YES NO
Name (s): _____
When did you take them? _____

Primary Care Physician: _____
Address: _____
_____
Phone #: _____ Date of Last Physical Exam: _____

Health/Medical Problems: YES NO Describe: _____

Past Head Injury or Loss of Consciousness? YES NO When? _____

Additional Medical Providers You See Regularly? YES NO
Name: _____ Phone #: _____
Address: _____

Name: _____ Phone #: _____
Address: _____

Emergency Contact (Required)**:** _____
Phone #: _____ **Cell Phone #:** _____

Billing Information
Insurance Company: _____
Member #: _____ Group #: _____
Person Financially Responsible for therapy sessions: _____
Address: _____
Phone #: _____

I acknowledge that payment is due at the time of service. I understand that if I fail to attend or cancel a scheduled session less than 24 hours in advance I will be charged a minimum of $75.00. I agree to be financially responsible for missed sessions and sessions cancelled less than 24 hours in advance. I also agree to pay for all services not covered by my insurance company.

Patient Signature: _____ Date: _____