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Patient Information Sheet

Name:______________________________________ Date:_____________________________

Address:____

City/State/Zip____

Home Phone:_______________________ Cell:________________ Work :___________________

Email:____

Age:________________ Date of Birth: _____________ Marital Status: __________________

Social Security Number: ____

Emergency Contact:____________________________________Phone______________________

Relationship to you: ____

Health

Name of Physician: ________________________________ Phone:_________________________

Date of last Physical Exam: ____

Medications: ____

Medical Conditions:____

Previous Psychotherapy

Former Psychological Treatment:

____

Provider's Name and Address:

____

____

Length of Treatment: ____

Have you ever been hospitalized for psychiatric reasons? If so, list dates and locations:

____

____

Education and Employment

Education: ____

Occupation: ____

Employer: ____

May I contact you at work? ____ yes ____ no

May I leave messages for you at work? ____ yes ____ no

Person Responsible for Payment (if other than self):

____

Address:____

City/State/Zip____

Home Phone:_______________________ Work Phone:______________________________

If Patient is a minor, Legal Guardian's Name:

____

Guardian's Address and Phone Number:

____

Family Information

List members of your family and all others in your home:

Name	Age	Relationship	Occupation
____________	__________	_____________	____________________
____________	__________	_____________	____________________
____________	__________	_____________	____________________
____________	__________	_____________	____________________
____________	__________	_____________	____________________
____________	__________	_____________	____________________

Current Concerns

Briefly describe your reason for seeking help at this time:

____

____

____

SIGNATURE:____________________________________ date:___________________________