

**Patient Information**

Date: \_\_\_\_\_

Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

Referral source for appointment: \_\_\_\_\_

May I send a letter back to the referral source with my recommendations?  Yes  No  N/A

Phone Numbers

May I leave a message at this number?

	Yes	No
Home: _____	<input type="checkbox"/>	<input type="checkbox"/>
Work: _____	<input type="checkbox"/>	<input type="checkbox"/>
Cell: _____	<input type="checkbox"/>	<input type="checkbox"/>

**Signature on File**

I understand that I am responsible for my bill and that I will be asked to pay in full at the conclusion of each therapy session. I will be provided an invoice that I may submit to my insurance company for reimbursement.

\_\_\_\_\_  
Name (Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Demographic Information:**

Marital Status:       Single    Married \_\_\_\_\_       Divorced \_\_\_\_\_  
                                   Separated \_\_\_\_\_       Living Together \_\_\_\_\_  
                                   Widowed \_\_\_\_\_

Employment:       Full Time    Part Time    Disabled    Retired    Homemaker  
 Employer \_\_\_\_\_ Length of Employment \_\_\_\_\_  
 Occupation \_\_\_\_\_

Education:       Elementary       High School       GED       Some College  
                           Trade       Associates       BA/BS       Post Grad

Current Student:    Full-Time       Part-Time  
 Major: \_\_\_\_\_

Please list all family members and persons living with you:

Name	Relationship to you	Date of birth	

**Medical History:**

Current Conditions:    No    Yes: \_\_\_\_\_

Surgeries/Serious Accidents:    No    Yes: \_\_\_\_\_

Physician: \_\_\_\_\_ Last Visit: \_\_\_\_\_

Currently being treated by a psychiatrist?    No    Yes (Please see below)

Name of psychiatrist: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Please list all medications you are currently taking (psychiatric and other):       None

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_  
 Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_  
 Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_  
 Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

**Previous Psychological Treatment:**  None

Outpatient: Therapists/Dates: \_\_\_\_\_

Reason(s) for prior therapy: \_\_\_\_\_

Inpatient Psychiatric: Where/Dates: \_\_\_\_\_

Reason(s): \_\_\_\_\_

Inpatient/Outpatient Chemical Dependency: \_\_\_\_\_

Current Alcohol Use: \_\_\_\_\_

Current Drug Use: \_\_\_\_\_

**Family History of Psychiatric/Substance Abuse Disorders:**  None

	Mother	Father	Siblings	Others
Alcohol Problems				
Drug Problems				
Anxiety				
Depression				
Schizophrenia				
Other				

**Reason for coming in today (what are your main concerns?):**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_