Patient Information Form

Today's date: _____

Your name: _____
Last First Middle Initial

Date of birth: _____ **Social Security #:** _____

Home street address: _____

City: _____ **State:** _____ **Zip:** _____

Name of Employer: _____

Address of Employer: _____

Name of School _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____
Cell Phone: _____ **Email:** _____
Calls will be discreet, but please indicate any restrictions: _____
_____

Referred by: _____
- May I have your permission to thank this person for the referral?
  ☐ **Yes** ☐ **No**
- If referred by another clinician, would you like for us to communicate with one another?
  ☐ **Yes** ☐ **No**

Person(s) to notify in case of any emergency: _____
Name Phone
I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): _____

Please briefly describe your presenting concern(s): _____
_____
_____
_____
_____

What are your goals for treatment?
_____
_____
_____
_____
_____

Are you now, or will be in the future, involved in any legal matter that would require documentation of your Diagnosis/Treatment

_____

_____

_____

Insurance Information:

Name of Insured_____DOB_____
Relationship to Patient _____
SSN#:_____ Name of Employer:_____
Work Phone: (____)_____
Address of
Employer:_____City_____State:_____
Zip _____
Insurance Company_____ Grp #_____
ID#_____
Ins Co Address:_____ Ins Co.
Phone:_____

DO YOU HAVE ANY ADDTIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ----------
Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of
Employer:_____City_____State:_____
Zip _____
Insurance Company_____ Grp #_____
ID#_____
Ins Co Address:_____ Ins Co.
Phone:_____

MEDICAL HISTORY:
Please explain any significant medical problems, symptoms, or illnesses: _____

_____

_____

Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Do you smoke or use tobacco? YES NO If YES, how much per day? _____
Do you consume caffeine? YES NO If YES, how much per day? _____
Do you drink alcohol? YES NO If YES, how much per day/week/month/year? ____
Do you use any non-prescription drugs? (Please remember that this form is completely confidential).
YES NO If YES, what kinds and how often? _____

Previous Hospitalizations: (Approximate dates and reasons):_____

Have you ever been treated by a psychiatrist, psychologist, or other mental health professional? YES NO
(Please list approximate dates and reasons): _____

FAMILY:

How would you describe your relationship with your mother? _____

How would you describe your relationship with your father? _____

Are you parent's still married or did they divorce?_____ If they divorced, how old were you when they separated or divorced, and how did this impact you? _____

Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life: _____

How many sisters do you have? _____ Ages? _____
How many brothers do you have? _____ Ages? _____
How would you describe your relationships with your siblings? _____

RELATIONSHIP STATUS:

Currently in Relationship? ____ How Long? ____ Relationship Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT
Married/Life Partnered? _____ How Long? _____ Previously Married/Life Partnered? YES NO
If so, length of previous marriages/committed partnerships_____
Do you have children?____ If YES, how many and what are their ages:_____
Describe any problems any of your children are having: _____

PLEASE CHECK ALL THAT APPLY & *CIRCLE* THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
Anxiety →			People in General →			Nausea →		
Depression			Parents			Abdominal Distress		
Mood Changes			Children			Fainting		
Anger or Temper			Marriage/Partnership			Dizziness		
Panic			Friend(s)			Diarrhea		
Fears			Co-Worker(s)			Shortness of Breath		
Irritability			Employer			Chest Pain		
Concentration			Finances			Lump in the Throat		
Headaches			Legal Problems			Sweating		
Loss of Memory			Sexual Problems			Heart Palpitations		
Excessive Worry			History of Child Abuse			Muscle Tension		
Feeling Manic			History of Sexual Abuse			Pain in joints		
Trusting Others			Domestic Violence			Allergies		
Communicating with Others			Thoughts of Hurting Someone Else			Often Make Careless Mistakes		
Drugs			Hurting Self			Fidget Frequently		
Alcohol			Thoughts of Suicide			Speak Without Thinking		
Caffeine			Sleeping Too Much			Waiting Your Turn		
Frequent Vomiting			Sleeping Too Little			Completing Tasks		
Eating Problems			Getting to Sleep			Paying Attention		
Severe Weight Gain			Waking Too Early			Easily Distracted by Noises		
Severe Weight Loss			Nightmares			Hyperactivity		
Blackouts			Head Injury			Chills or Hot Flashes		

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems		Physical Abuse		Depression			
Legal Trouble		Sexual Abuse		Anxiety			
Domestic Violence		Hyperactivity		Psychiatric Hospitalization			
Suicide		Learning Disabilities		"Nervous Breakdown"			

Any additional information you would like to include:

_____

_____

_____

_____

Authorization for Treatment/Release of Authorization/Assignment of Benefits

I authorize medical/psychological/clinical therapy treatment. I also authorize the release of any information necessary to process my insurance claims. I authorize and request payment of medical benefits directly to Provider. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment. I understand and agree to pay for missed appointments not canceled with 24 or more hours' notice.

Signed_____
Date_____

We will need your co-pay, as well as a copy your insurance and driver's license. Please present these items with this completed form. Thank you