Patient Information

Name ________________________________ Preferred Name: ________________________

- Legal guardian name (*if patient is a minor or dependent adult*): ________________________
- Legal guardian name (*if patient is a minor or dependent adult*): ________________________

Birth date: ________________ Age:_____Gender: __________ Ethnicity: ______________

Address: ____
(Street +/- Unit #) *(City, State)* *(Zip Code)*

Spouse/Partner Name *(if applicable)*: ____

Referral source: ____

Reason(s) for seeking help at this time: ____

____

***Please only list contact information that you approve for us to contact you & leave a message if necessary:**

	Approved Contact Information
Preferred Phone Number	
Home Phone Number	
Mobile Phone Number	
Work Phone Number	
Email Address	
Fax Number	

EMERGENCY CONTACT INFORMATION

Name: ________________________________ Phone Number: ________________________

Relationship to you ________________________ Email: ____________________________

***Please list all other involved healthcare providers:**

Type of Provider	Name	Phone Number
Primary Care Physician		
Psychotherapist		
Other:		
Other:		

***Please list all current prescription medications & dosages:**

Medication & dosage	Medication & dosage
1)	4)
2)	5)
3)	6)

Pharmacy Name: ________________________ Phone Number:________________________

Pharmacy Address:____
(Street +/- Unit #) *(City, State)* *(Zip Code)*