



Patient Information

TODAY'S DATE REFERRAL SOURCE
NAME NICKNAME SSN
DATE OF BIRTH AGE GENDER ETHNICITY
ADDRESS Street Apartment # City State Zip Code

PHONE NUMBERS: \*(Please only list phone numbers/email/fax that it is ok for provider to contact you and leave message)
Home Cell Work

EMAIL ADDRESS: FAX NUMBER:

MARITAL STATUS: Single Married Partnered Separated Divorced Widowed

LIVING WITH SPOUSE/PARTNER? Yes No NUMBER OF YEARS TOGETHER

EMPLOYER/SCHOOL OCCUPATION

HIGHEST LEVEL OF EDUCATION

CHILDREN Yes No AGES OF CHILDREN \*(Please circle ages of children living in home)

PRIMARY CARE PHYSICIAN HOSPITAL/CLINIC

(a) ADDRESS

(b) PHONE NUMBER FAX NUMBER

EMERGENCY CONTACT(S)

(1) NAME (2) NAME

PHONE NUMBER PHONE NUMBER

RELATIONSHIP TO PT RELATIONSHIP TO PT

TYPE OF HELP DESIRED:

Psychiatric Evaluation Medication management Individual Therapy Family/Couple's Counseling

- 1. Major reason(s) for seeking help at this time:
2. How long have you had these problems or symptoms?
3. How often do they occur?
4. List the people, activities, groups, and hobbies that are supportive to you/your family:



5. What are your goals for treatment? \_\_\_\_\_

6. What treatments have you tried already? \_\_\_\_\_

7. Are you currently taking any medications for medical problems (including over-the-counter and herbal)?  Yes  No  
 If yes, please list: \_\_\_\_\_

8. Do you have any serious or chronic medical conditions (including past surgeries)?  Yes  No  
 If yes, date(s) and details: \_\_\_\_\_

9. Do you have a history of serious accidents or injuries, head injury, loss of consciousness, or seizures?  Yes  No  
 If yes, date(s) and details: \_\_\_\_\_

10. Past and Current Psychological/Psychiatric Treatment:

	<i>Therapist (MD, PhD, MFT, etc.)</i>	<i>Type of therapy</i>	<i>Dates</i>	<i>Helpful (Y/N)</i>
Counseling or Psychotherapy Yes <input type="checkbox"/> No <input type="checkbox"/>	1.			
	2.			
	3.			
	4.			

	<i>Name of Medication?</i>	<i>Prescribed by</i>	<i>Year</i>	<i>Helpful (Y/N)</i>
Psychiatric Medications Yes <input type="checkbox"/> No <input type="checkbox"/>	1.			
	2.			
	3.			
	4.			

	<i>Where?</i>	<i>Admission Reason?</i>	<i>Year</i>	<i>Helpful (Y/N)</i>
Psychiatric Hospitalizations Yes <input type="checkbox"/> No <input type="checkbox"/>	1.			
	2.			
	3.			
	4.			

	<i>Where?</i>	<i>Admission Reason?</i>	<i>Year</i>	<i>Helpful (Y/N)</i>
Addiction Rehab/Treatment Yes <input type="checkbox"/> No <input type="checkbox"/>	1.			
	2.			
	3.			
	4.			