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)*