PATIENT INFORMATION **Today's Date: _____**

Patient Name: _____/_____/_____
First MI Last

Name you like to be called: _____

Patient Address: _____
Street

_____ _____ _____
City State Zipcode

Phone: Home_____ Cell: _____
Work: _____

E-mail address: _____

How may we contact you: Home ___ Cell___ Work___ Email___ (Check all that apply or 'P' for preferred method)

Birth date: _____ Age: _____ Gender: Male ___ Female ___

SS # _____-_____-_____

Ethnicity: Caucasian ____ African-American ____ Asian ____ Hispanic ____ Other _____

Relationship Status: Single ___ Married ____yrs Serious relationship _____yrs Divorced _____yrs

Children? Yes, ages _____ No _____

Occupation/Work:_____

Student? No ____ Yes, school name_____

Education: _____
(highest level of education, degree, major/specialization)

Financially Responsible Party (if different from patient): _____
_____
Relationship

Phone: _____Address: _____
Street

_____ _____ _____
City State Zipcode

How did you first find out about our services?_____

Emergency Care Information
Primary Care Physician: Name: _____
Phone: _____
Address: _____
Street

_____ _____ _____
City State Zipcode

May we contact your personal physician to discuss medical or medication issues and/or coordinate your care?
No ___ Yes ___ If yes, please complete/sign "Consent" form in attached paperwork.

Family and/or friends to be contacted in an emergency:
Name:
_____Relationship_____Phone:_____
Name:
_____Relationship_____Phone:_____

Current Concerns
Please provide a brief description of the major concerns that led you to seek treatment/therapy at this time:

_____
_____
_____

Previous Psychiatrist/Therapist
Name of clinician: Phone Number/ Treatment dates

_____ _____
_____ _____
_____ _____

MEDICATIONS:
Please list all current drugs/medications, including over-the-counter:

Name of medication:	Dose	Dates

Please list any previous psychiatric drugs/medications:

Name of medication:	Dose	Dates

MEDICATION ALLERGIES:

_____
_____

Physical Health Status
Do you have any existing medical problems or current physical symptoms of concern to you? If so, please describe.

_____
_____
_____

Please indicate any major illnesses, accidents, and/or hospitalizations within the last 5 years:

_____
Date:_____
_____

Health Insurance Information

Type: _____

PPO: Yes _____No _____

Member ID number:_____

Group ID name and/or number: _____

Phone: _____
Address: _____
Street

_____ _____ _____
City State Zipcode

Pharmacy Information

Name: _____
Phone: _____
Address: _____
Street

_____ _____ _____
City State Zipcode