Patient Information

The information collected on this form will prevent us from having to go over your psychosocial history in depth in session. If you would fill it out, I will read it either before our first or second session depending on when you can fill out the paperwork.

Date _____/_____/_____

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status: □ Never Married □ Domestic Partnership/Civil Union □ Married
□ Separated □ Divorced □ Widowed

Please list any children/age: _____

Address: _____
(Street and Number)
_____
(City) (State) (Zip)

Home Phone: ( ) _____ May we leave a message? □ Yes □ No

Cell/Other Phone: ( )_____ May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Emergency Contact Name: _____ Relationship to you? _____
Telephone Number _____

Are you using an EAP benefit? (if yes, please provide name & authorization #)
_____

Insurance Company Name and Address: _____

Identification Number: _____ Group Number _____

Responsible Party Name and Date of Birth (if other than self): _____
_____

Referred by (if any): _____
May we contact them to thank them (Please provide contact information if yes)_____

EMPLOYMENT INFORMATION

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation: □ Full Time □ Part-time □ Unemployed
□ On Disability □ Minor/not employed

Employer Name _____

Job Title: _____

If Student: □ Full-time □ Part-time School/College _____

2. Do you enjoy your work/school? Is there anything stressful about your current work/school?

_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

Name of Primary Care Physician (PCP): _____

PCP Address & Phone: _____

□ **I do** / □ **I do not** wish for my PCP to be occasionally informed about my treatment

Signature _____ Relationship to patient _____
Date: _____

1. Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No □ Yes Name of Therapist(s): _____

Have you ever been prescribed psychiatric medication? □ Yes □ No

Please list and provide dates: _____

_____

2. How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

3. How would you rate your current sleeping habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

4. How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

5. Please list any difficulties you experience with your appetite or eating patterns:

_____

6. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes
If yes, for approximately how long? _____

7. Are you currently experiencing anxiety, panic attacks or have any phobias? □ No □ Yes
If yes, when did you begin experiencing this? _____

8. Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe _____

9. Do you drink alcohol more than once a week? □ No □ Yes

10. How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never

11. Are you currently taking any prescription medication? □ Yes □ No

Please list: _____

_____

12. Do you have any allergies? _____

13. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

14. What significant life changes or stressful events have you experienced recently:

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	

Eating Disorders	yes/no
Obesity	yes/no
Obsessive Compulsive Behavior	yes/no
Schizophrenia	yes/no
Suicide Attempts	yes/no

ADDITIONAL INFORMATION:

1. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

_____

2. What do you consider to be some of your strengths?

_____

_____

3. What do you consider to be some of your weakness?

_____

_____

4. What would you like to accomplish out of your time in therapy?

_____

_____

_____