

**Confidential
Patient Information**

DRIVER'S LICENSE # _____
HEALTH INSURANCE – POLICY #, GROUP #, ID # _____

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 Divorced Married Separated Widowed

Please list any children/age: _____

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

Home Phone: (____)____-____ May we leave a message? Yes No

Mobile/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 & Phone): _____

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

No
 Yes If yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?

No
 Yes If yes, please list: _____

Have you ever been prescribed psychiatric medication?

No
 Yes If yes, please list and provide dates: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION:

1. How would you rate your current physical health?

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing: _____

2. How would you rate your current sleeping habits?
 Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing: _____

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

What types of exercise/activities do you participate in? _____

4. Please list any difficulties you experience with your appetite or eating patterns _____

5. Are you currently experiencing overwhelming sadness, grief or depression?

No
 Yes If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?

No
 Yes If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?

No
 Yes If yes, please describe? _____

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

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

10. 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? _____

11. 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.).

<input type="checkbox"/> Alcohol/Substance Abuse		<input type="checkbox"/> Eating Disorders	
<input type="checkbox"/> Anxiety		<input type="checkbox"/> Obesity	
<input type="checkbox"/> Depression		<input type="checkbox"/> Obsessive Compulsive Behavior	
<input type="checkbox"/> Domestic Violence		<input type="checkbox"/> Suicide Attempts	
<input type="checkbox"/> Schizophrenia		<input type="checkbox"/> Other:	

ADDITIONAL INFORMATION:

1. Are you currently employed?

No

Yes If yes, what is your current employment situation: _____

Do you enjoy your work? Is there anything stressful about your current work? _____

2. Do you consider yourself to be spiritual or religious?

No

Yes If yes, describe your faith or belief: _____

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

4. What do you consider to be some of your weaknesses?

5. What would you like to accomplish with your time in therapy? _____

I hereby authorize the use of this signature on all my insurance submissions, and also certify that all insurance information given to this office is correct and complete. I hereby authorize this office to release all information necessary to process my insurance claim(s) and to secure the payment of benefits.

Client Signature: _____

Date: _____

Guardian Signature: _____

Date: _____