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PATIENT INFORMATION

Date: _____ / _____ / _____

Patient Name: _____ Date of Birth: _____ Age: _____

Home Address: _____

City, State, Zip Code: _____

Telephone: Home: _____ Work: _____ Cell: _____

Sex: □ Male □ Female Marital Status: □ Single □ Married □ Divorced □ Widowed

Health Plan & Member Subscriber ID#: _____

Patient employer/If patient is a minor indicate School/Grade: _____

_____

Reason for requesting psychotherapy: _____

_____

Have you been treated for mental health services before? _____

_____

If yes, what dates and with whom? Please list treating clinician's name: _____

_____

Are you currently taking any medications? If yes, please list: _____

_____

If this is a referral, please share the name of the person who referred you: _____

May I have your permission to thank this person for the referral? ☐Yes ☐No

If this is not a referral, how did you hear about me? ☐Web Search ☐Insurance Provider
☐PsychologyToday.com ☐Other *(please explain)*: _____

Current religious affiliation: ☐Protestant ☐Catholic ☐Jewish ☐Islamic ☐Buddhist
☐Hindu ☐Other *(please specify)*: _____

Level of Involvement: ☐None ☐Some/Occasional ☐Active

Which church, synagogue, temple or meeting *(if any)* are you involved with?_____

How important are spiritual concerns in your life? ☐None ☐Some ☐Very Much

Ethnicity/national origin or other way you identify yourself and consider important:

_____

RESPONSIBLE PARTY INFORMATION

If the patient is a minor or unemployed, please provide information about the person responsible for making payments:

Name: _____ Date of Birth: _____ Age: _____

Home Address: _____

City, State, Zip Code: _____

Telephone: Home: _____ Work: _____ Cell: _____

Sex: □ Male □ Female Marital Status: □ Single □ Married □ Divorced □ Widowed

Health Plan & Member Subscriber ID#: _____

Relationship to Patient: _____

Employer: _____

Business Address: _____

SPOUSE / SIGNIFICANT OTHER INFORMATION

If the patient is a minor, please provide information about the other parent or guardian:

Name: _____ Date of Birth: _____ / _____ / _____ Age: _____

Home Address: _____

City, State, Zip Code: _____

Telephone: Home: _____ Work: _____ Cell: _____

Sex: □ Male □ Female Marital Status: □ Single □ Married □ Divorced □ Widowed

Health Plan & Member Subscriber ID#: _____

Employer: _____

EMERGENCY CONTACT INFORMATION

Primary Care Physician: _____ Telephone: _____

Emergency Contact: _____ Relationship: _____

Telephone: Home: _____ Work: _____ Cell: _____

I understand that the above is true and correct to the best of my knowledge.

_____ _____

Patient Date

_____ _____

Patient *(if applicable)* Date

_____ _____

Parent, Caregiver or Legal Guardian *(if applicable)* Date

_____ _____

Parent, Caregiver or Legal Guardian *(if applicable)* Date