

# 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) \_\_\_\_\_

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**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:

\_\_\_\_\_

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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:

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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:

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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: \_\_\_\_\_

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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:

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

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

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

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