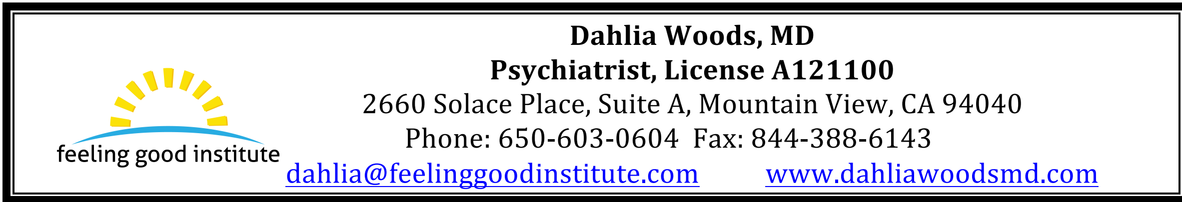

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PATIENT INFORMATION FORM

The following information will help us to get started with treatment as quickly as possible. Please complete as much information as possible prior to our first appointment.

General Information

Date: _______________

Legal Name: ____

Preferred Name (if different): ____________________________________

Age: _____________ Date of Birth: _________________________________

Mailing Address: ____

____

Ok to mail treatment related information? Yes / No

Preferred Phone Number: ___________________________________ mobile/home/office/other: _________

Ok to leave voicemail? Yes / No

Other Phone Number: ___________________________________ mobile/home/office/other: ____________

Ok to leave voicemail? Yes / No

Email: ____

Ok to email treatment related information? Yes / No

Who referred you to me? ____

May I thank that person for the referral? Yes / No

Occupation: ______________________________________ Employer: ____________________________________

Relationship Status: ____

With whom do you live: ____

Religious Affiliation: ____

Ethnic/Cultural Identity: ____

Sexual Identity/Orientation (lesbian/gay/bisexual/heterosexual/other): ___________________________

Gender Identity (male/female/transgender/other): ____

In case of an emergency, please provide a contact person:

Emergency Contact Person: ______________________________________ Relation: _______________________

Address: ____

Phone: ____ mobile/home/office/other: ________

Email: ____

Current Mental Health Information

1. Please place a check next to the symptoms or struggles you are experiencing:

___ anxiety
___ worrying/nervousness
___ fears/phobias
___ obsessions
___ shyness
___ procrastination
___ depression
___ sadness
___ tearfulness
___ loneliness
___ poor concentration
___ insomnia/sleep
___ fatigue
___ low self-esteem
___ hopelessness
___ thoughts of suicide
___ urge to harm others
___ irritability/anger
___ impulsivity
___ alcohol abuse
___ drug abuse
___ work concerns
___ academic concerns
___ parenting concerns
___ headaches
___ stress
___ relationship stress
___ divorce/separation
___ grief/death/loss
___ social skills
___ life transitions
___ discrimination
___ sexual identity
___ LGBTQI concerns
___ gender identity
___ gender roles
___ transgender identity
___ cultural issues
___ familial conflict
___ generational conflict
___ eating problems
___ physical pain
___ sexual abuse/trauma
___ other abuse/trauma
___ abusive relationship (past)
___ abusive relationship (current)
___ ability/disability status
___ financial concerns
___ access to housing
___ other: ___________________
___ other: ___________________
___ other: ___________________

2. Please describe how you have been feeling: ____

____

____

3. Current sleep pattern (hours/night): ____

4. Current eating habits: ____

5. Current exercise habits: ____

6. Tobacco? Yes / No How much/day? ____

7. Alcohol? Yes / No How much? How often? ____

8. Drugs? Yes / No How much? How often? ____

9. Are you presently seeing another therapist? Yes / No

If yes, provide name of provider: ____

Phone: _______________________ Address: ____

Fax: __________________________ Email: ____

Date of last visit ____

10. Are you currently receiving a prescription for psychiatric medications? Yes / No

If yes, provide name of provider: ____

Phone: _______________________ Address: ____

Fax: __________________________ Email: ____

Date of last visit ______________________________

11. Current psychiatric medication(s): ______________________________

____

____

12. Please briefly describe your goals for treatment: ______________________________

____

____

Mental Health History

1. Have you ever seen a psychiatrist? Yes / No Starting at what age? ______________
2. Have you been diagnosed with a mental health condition? Yes / No

If yes, please describe: ______________________________

____

____

3. Have you ever been hospitalized for a psychiatric problem? Yes / No

If yes, please describe: ______________________________

____

4. Have you ever attempted suicide? Yes/No

If yes, please describe: ______________________________

____

5. Have you had past psychotherapy/counseling experiences? Yes / No

If yes, please describe: ______________________________

____

____

6. Does anyone in your family have mental illness or problems with drugs or alcohol? Yes / No

If yes, please describe: ______________________________

Medical Information

1. Past medical history (with date of onset): ______________________________

____

2. History of head trauma or seizures? Yes / No

If yes, explain: ______________________________

3. Past surgical history (with dates) ______________________________

____

4. Current medications (non-psychiatric): ______________________________

____

____

5. Allergies: ____

6. Primary Care Physician: ____

Phone: ____________________________ Address: ____________________________________

Fax: ____________________________ Email: ______________________________________

Date of last visit ____

7. Last date you had labs done (blood work, EKG, brain imaging, etc.) ________________________

Lab results (if known): ____

____

Please bring copies of relevant records to your first appointment.

Females Only

1. Age of onset of menstruation: ____

2. Menses: regular / irregular How often? Duration? Flow? ______________________________

3. Date of LMP: ________________

4. History of prior pregnancies: ____

5. Could you be pregnant now? Yes / No

6. Are you breastfeeding? Yes / No

7. Birth control? Yes / No Method: ____

8. Obstetrician/Gynecologist: ____

Phone: ____________________________ Address: ____________________________________

Fax: ____________________________ Email: ______________________________________

Date of last visit ____

Support Systems & Coping

1. From who do you primarily receive support in your life? ______________________________

____

2. Are you satisfied with your social support system? Not at all / Somewhat / Very Much So

3. What strategies have you used to cope with or manage your current struggles/problems?

____

4. Please list some of your strengths (things you are proud of): __________________________

____

5. Is there anything else you would like me to know about at this time? ______________________

____