

Patient Information

Date: _____ Patient # _____

Name: _____ Social Security # _____ Home Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail address: _____ Cell Phone: _____

Age: _____ Birth Date: _____ Marital Status: Married Single Separated Divorced Widow(er)

Occupation: _____ Employer: _____

Employer's Address: _____ Work Phone _____

Spouse: _____ Occupation: _____ Employer: _____

How many children? _____ Names and Ages of Children: _____

Emergency Contact: _____ Phone: _____

How were you referred to our office? _____

Family Medical Doctor (first and last name): _____

FINANCIAL

I plan to use my insurance to cover the cost of my therapy. (Provide insurance card to be copied.)

Please give information for primary insured... Relationship to patient: Spouse ___ Parent ___

Name _____ Date of birth _____ SS# _____

I want to pay for my therapy.

My EAP has authorized ___ visits. Authorization number _____

PAST HISTORY

Are you experiencing any of the following: (Place a check mark by conditions that apply to you)

- | | | |
|-------------------------------------|---|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Adoption issues |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Communication issues | <input type="checkbox"/> Post Traumatic Stress Disorder |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Abandonment issues |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Parenting issues | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Stress | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Other _____ |

List any major illness, hospitalizations or surgeries: _____

Have you been treated for any health condition by a physician in the last year? ___ Yes ___ No

If yes, describe: _____

What medications or drugs are you taking? _____

Please list any other health problems you have, no matter how insignificant they may be: _____

HISTORY OF PRESENT PROBLEM:

Purpose of this appointment: _____

Have you ever had the same or a similar condition? Yes No If yes, when and describe: _____

SOCIAL HISTORY:

Do you drink alcoholic beverages? _____ If so, how much per week? _____

Do you use any tobacco products? _____ Do you smoke? _____ If so, packs per day: _____

Do you take vitamin supplements? _____ If so, please list: _____

Do you consume caffeine? _____ If so, how much per day: _____

Do you exercise? _____ If yes, what is the frequency and type of exercise? _____

Do you sleep well at night? _____ If no, why not? _____

What are your hobbies? _____

What percentage of time during the day (at home or at your job away from home) do you spend:

Under normal stress load: _____% Under considerable stress: _____% Resting or relaxed: _____%

FAMILY HISTORY:

Father: (check one) living deceased Current age if still living: _____

Cause of death and age at death if deceased: _____

Mother: (check one) living deceased Current age if still living: _____

Cause of death and age at death if deceased: _____

Do you have any family members who suffer from the same condition you do? _____ If so, please list: _____

Family Diseases (if applicable) - indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

- | | | |
|-------------------------------------|---|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Adoption issues |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Communication issues | <input type="checkbox"/> Post Traumatic Stress Disorder |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Abandonment issues |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Parenting issues | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Stress | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Other _____ |

Patient's Signature _____ Date _____

If patient is a minor, the parent or guardian must sign below to consent to the minor receiving treatment.

Parent/Guardian Authorizing Care _____ Date _____