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Psychotherapy and Counseling

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PATIENT INFORMATION

Please print clearly

Please provide the following information and answer the questions on both pages. Please note: information you provide here is protected as confidential information.

Date: ______________________________

Name: ______________________________

Address: (home) ______________________________

City and Zip: ______________________________

Phone Numbers:

Home: ______________________________

Work: ______________________________

Cell/Mobile: ______________________________

Fax: ______________________________

Email: ______________________ May I email you? ____No ____Yes

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Date of Birth: ______________________ Age: ____________

Marital Status: ______________________________

Social Security # (optional and confidential) ______________________________

Employer: ______________________________

Occupation: ______________________________

Education (List highest degree: ______________________________

Emergency Contact:

Name: ______________________ Relationship: ____________

Phone: ______________________________

Referred by: ______________________________

Primary Physician: ______________________________

Phone: ______________________________

Address: ______________________________

City and Zip: ______________________________

List any significant health problems: ______________________________

____

Current medications, dosage and reason for taking : ______________________________

____

____

Prior psychotherapy: NO___ YES___ If yes, when and how long: ______________

____

Give a brief description of treatment (if applicable): ______________________________

____

Briefly describe what brings you in today: ______________________________

____

____

What are your goals for therapy? ____

____

Please check any of the following that describe how you have been feeling **lately:**
____*sad* ____*anxious* ____*depressed* ____*lonely* ____*guilty* ____*angry* ____*ashamed* ____*aggressive*
____*resentful* ____*worthless* ____*tearful* ____*irritable* ____*confused* ____*jealous* ____*panic attacks*
____*moodiness* ____*hopeless* ____*helpless* ____*suicidal thoughts/wishing you were dead*

Describe any other feelings you have had: ________________________________

____

What activities or hobbies do you participate in? ____________________________

____

Do you participate in regular exercise? ____No ____Yes. If yes, describe: ____________

____

Have you had any change in sleep habits? ____No ____Yes. If yes, describe: ____________

____

Have you ever ***considered suicide***? ____No ____Yes. If yes, when and please describe:________

____

____

Have you ever ***attempted suicide?*** ____No ____Yes. If yes, when and please describe:________

____

____

Is there a family history of suicide? ____No ____Yes. If yes, please describe: ____________

____

____

Have you had any ***homicidal thoughts?*** ____No ____Yes. If yes, please describe: __________

____

____

Please list any substances you use (alcohol, marijuana, caffeine, tobacco, heroin, cocaine, etc):
How often? ____

Is there a family history of alcohol or substance abuse? ____No ____Yes

Are you currently in a romantic relationship? ____No ____Yes. If yes, for how long?

____

Describe your current support system (family, friends, organizations, etc): ____________

____

Do you have any pets: No ______ Yes ______. If yes, please describe ____________

____