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PATIENT INFORMATION SHEET

Name: _____ Date: _____

Address: _____

_____

Phone: _____ Email: _____

Racial Identity/Identities: _____

Sexual Orientation/Gender/Preferred Pronouns:: _____

Date of Birth: _____ Age: ____ Marital/Partner Status: _____

Emergency Contact: _____ Phone: _____

Relationship to you: _____

HEALTH

Name of Physician: _____ Phone: _____

Date of Last Physical Exam: _____

Medications: _____

_____

Significant Medical History (chronic conditions, accidents, major illnesses or surgeries):

_____

_____

PREVIOUS PSYCHOLOGICAL TREATMENT

Type/Length of Treatment:_____

_____

Provider's Name: _____

_____

Have you ever been hospitalized for psychiatric reasons? If so, list dates and locations:

_____

Who referred you? _____

EDUCATION AND EMPLOYMENT

Education:_____

Occupation:_____

Employer: _____

Person Responsible for Payment (if other than self?)_____

Address: _____

City/State/Zip: _____

Home Phone: _____ Work Phone: _____

If Patient is a minor, Legal Guardian's Name: _____

Guardian's Address and Phone Number: _____

FAMILY INFORMATION

List members of your family:

Name	Age	Relationship	Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CURRENT CONCERNS

Briefly describe your reasons for seeking help at this time: _____

_____

_____

_____

_____

Signature _____ Date _____