PATIENT INFORMATION

Name _____Today's date_____

Address_____

_____

PHONE: Home_____Work_____Cell_____

Date of Birth_____ Current age _____

Current medical doctor _____

Health problems (if any) _____

Current medications: Medication Reason Taking

_____ _____

_____ _____

_____ _____

_____ _____

List others living in your household:

Name	Age	Relationship to you
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

INSURANCE INFORMATION

If you plan to use insurance, please fill out the following:

Name of insurance company_____

Address of insurance co._____

_____

Name of main policyholder_____

Relationship of policyholder to you_____

Address of policyholder _____

_____

Policyholder's date of birth _____

Policyholder's Social Security # _____

Policyholder's ID number _____

Policy number_____Group number _____

Policyholder's employer_____

*****

PLEASE REMEMBER THAT YOU WILL BE CHARGED FOR CANCELLATIONS UNLESS YOU GIVE AT LEAST 24-HOURS NOTICE. (Insurance does not cover canceled or "no show" appointment charges.)

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Signature_____

Who referred you to me?_____

Briefly describe why you are seeking help or consultation:_____

_____

_____

Have you ever been in therapy or received psychiatric care before? YES NO

If yes, explain:_____

_____

Please circle as many of the following that you feel are problems for you in your life:

Anxiety	Unhappiness	Finances	Family Difficulties
Eating	Sleep	Irritability	Health
Abuse	Anger	Sadness	Job Dissatisfaction
Self-Injury	Stress	Drugs	Decision Making
Tiredness	Alcohol	Divorce	Romantic Difficulties
Fears	Sex	Worry	Suicidal Thoughts
Concentration	Depression	Shyness	Worthlessness
Loneliness	Disorganization	Lack of pleasure	Low self esteem

OTHER:_____