

Patient Information

Please complete the following form as accurately as possible

NAME: _____

DATE: _____

SPONSOR'S SS# _____

PHONE # _____

CELL PHONE # _____

ADDRESS _____

DATE OF BIRTH: _____

AGE: _____

GENDER: _____

ETHNIC BACKGROUND(S): _____

OCCUPATION: _____

EMPLOYER: _____

NAME of REFERRING PHYSICIAN: _____

PHONE # of REFERRING PHYSICIAN: _____

NAME OF PREVIOUS THERAPISTS AND DATES SEEN:

LIST ANY HEALTH CONCERNS:

LIST MEDICATIONS YOU CURRENTLY USE:

DO YOU HAVE MILITARY SERVICE? Y N Does your spouse? Y N

ACTIVE DUTY yes/no
RETIRED yes/no
OF YEARS in MILITARY _____
OF DEPLOYMENTS _____
APPROXIMATE DATES OF DEPLOYMENTS

ACTIVE DUTY yes/no
RETIRED yes/no
OF YEARS in MILITARY _____
OF DEPLOYMENTS _____
APPROX. DATES OF DEPLOYMENTS

MEDICAL BOARD yes/no
PENDING PCS or ETS yes/no date _____

MEDICAL BOARD yes/no
PENDING PCS or ETS yes/no
date _____

MARITAL STATUS:

MARRIED yes/no SPOUSES NAME: _____

SPOUSES PHONE NUMBER: _____

NUMBER OF PREVIOUS MARRIAGES _____

CHILDREN FROM CURRENT MARRIAGE: NAMES & AGES

CHILDREN FROM PREVIOUS MARRIAGE: NAMES & AGES:

NAME/AGE/RELATIONSHIP OF ALL PERSONS LIVING IN YOUR HOME:

WHAT ADULT, NOT LIVING IN YOUR HOME, WOULD YOU TRUST TO WATCH YOUR CHILD/CHILDREN, IN THE CASE OF EMERGENCY?

PLEASE INCLUDE NAME, ADDRESS, AND PHONE NUMBER & RELATIONSHIP:

PLEASE DESCRIBE WHAT BRINGS YOU HERE TODAY:

PLEASE CHECK ANY OF THE FOLLOWING ITEMS THAT CONCERN OR APPLY TO YOU:

- () Thoughts of suicide in the past
- () Current thoughts of suicide
- () Previous suicide attempts
- () Thoughts of harming people, property, or animals in the past month
- () Self Mutilation in the past or currently (Cutting, etc)

PLEASE DESCRIBE ANY SUBSTANCES YOU ARE USING: DESCRIBE FREQUENCY & AMOUNT (alcohol, drugs, nicotine, etc.):

PLEASE DESCRIBE ANY LEGAL ISSUES (PAST OR CURENT):

WHO WOULD YOU LIKE FOM ME TO CALL IN THE CASE OF AN EMERGENCY?

NAME_____

CELL PHONE NUMBER_____

AUTHORIZATION:

I, _____ BY

SIGNING THIS FORM, ACKNOWLEDGE THAT THE INFORMATION PROVIDED IS ACCURATE AND TRUE.

CLIENT SIGNATURE:

SIGNATURE OF PARENT IF CLIENT IS A MINOR:
