PATIENT INFORMATION FORM

Name _____ Today's Date _____

Address _____ Phone _____

City _____ Zip Code _____ Date of Birth _____ Age _____

Marital Status_____ Email _____

Emergency Contact Name and Phone # Social Security #_____

_____ Education Level _____

Financial Information:

Annual household income _____ Do you own or rent? _____

Occupation? _____ Employer? _____

If planning to use health insurance:

Name of insurance company _____ Policy Holder_____

Policy number _____ Group # _____ Tel._____

SS # of policy holder_____ Birthdate of Policy Holder _____

Psychological History:

Have you ever received mental health treatment before? _____

Approximate date/ focus of treatment? _____

Name of treating therapist? _____

Have you ever been hospitalized for mental or emotional problems? _____

When? _____ Duration of hospital stay? _____

Do you take any prescription medications for a mental/emotional condition?_____

Please list name of prescriptions and dosage. _____

_____

Have you ever attempted suicide? _____When? _____

Describe the circumstances that led to that attempt. _____

_____

Are you currently having any suicidal thoughts? Please describe _____

_____

Medical History:

Have you ever been diagnosed with a serious illness? If yes, please describe _____

_____

Do you have any medical issues that may affect your mental health treatment? _____

If yes, please describe _____

Have you ever been in a 12-step program? Describe _____

On average, how much alcohol, if any, do you consume in a week? _____

Do you currently use illegal drugs? If yes, please describe your use_____

_____

Other Information:

Please describe your spiritual identity/orientation _____

Please describe your interests/hobbies _____

Are you now or have you ever been involved in a lawsuit? _____

Please describe _____

Please check off any of the following items that may pertain to the patient's reasons for seeking mental health counseling services at this time:

☐Impulsivity
☐Headaches
☐Worry/Nervousness
☐Shyness
☐Drug Use
☐Anger
☐Sleep Disturbance
☐Relationship
☐Legal Matters
☐Fatigue/Tiredness
☐Loneliness
☐Education
☐Family Relations
☐Addiction

☐Suspiciousness
☐Assertiveness
☐Insomnia
☐Euphoria/Too Much
☐Energy
☐Troublesome Thoughts
☐Recurrent Thoughts
☐Binge Eating
☐Sadness/Depression
☐Sexual Problems
☐Alcohol Use
☐Low Self Esteem
☐Self-Control

☐Inferiority Feelings
☐Nightmares
☐Weight Control
☐Financial Problems
☐Abuse
☐Mood Swings
☐Fears
☐Suicidal Thoughts
☐Unhappiness
☐Work
☐Making Decisions
☐Stress
☐Health Problems
☐Appetite

☐Body Image
☐Anorexia/Bulimia
☐Social Isolation
☐Chronic Pain
☐Grief
☐Marital Problems
☐Guilt
☐Parenting Concerns
☐Self-Injury/Cutting
☐Divorce/Separation
☐Post Traumatic Stress
☐Stomach Trouble
☐Poor Concentration