PATIENT INFORMATION FORM

Please complete as much information as possible prior to the first appointment. Doing so will help us to get started with treatment as quickly as possible.

General Information

Date: _____

Legal Name: _____

Preferred Name (if different): _____

Age: _____ Date of Birth: _____

Mailing Address: _____

_____

Ok to mail treatment related information? Yes / No

Preferred Phone Number: _____ mobile/home/office/other: _____

Ok to leave voicemail? Yes / No

Email: _____

Ok to email treatment related information? Yes / No

Whom Referred you? _____ May I thank that person? Yes / No

Ethnic/Cultural Identity: _____

Religious Affiliation: _____

Involvement in religious activities: none some/irregular active

Emergency Contact

In case of an emergency, please provide a contact person:

Emergency Contact Person: _____ Relation: _____

Address: _____

Phone: _____

Email: _____

Education or Work

Highest level of education: _____

List any problems with school/adjustment to school: _____

Employment status: full-time part-time homemaker unemployed retired disabled student

Occupation: _____ Employer: _____

List any career/work problems: _____

Social or Family

Sexual Identity/Orientation (lesbian/gay/bisexual/heterosexual/other): _____

Gender Identity (male/female/transgender/other): _____

With whom do you live: _____

Relationship Status: single married/partnered separated divorced widowed

If married/partnered- List partner's name, age, length of time together: _____

_____

How well do you get along with your current spouse or partner? _____

_____

Number and ages of children: _____

How do you get along with your children? _____

Current Mental Health Information

1. Please place a check next to the symptoms or struggles you are experiencing:

___ anxiety	___ worrying/nervousness	___ fears/phobias
___ obsessions	___ shyness	___ procrastination
___ depression	___ sadness	___ tearfulness
___ loneliness	___ poor concentration	___ insomnia/sleep
___ fatigue	___ low self-esteem	___ hopelessness
___ thoughts of suicide	___ urge to harm others	___ irritability/anger
___ impulsivity	___ alcohol abuse	___ drug abuse
___ work concerns	___ academic concerns	___ parenting concerns
___ headaches	___ stress	___ communication skills
___ divorce/separation	___ grief/death/loss	___ social skills
___ life transitions	___ discrimination	___ sexual identity
___ LGBTQI concerns	___ gender identity	___ gender roles
___ transgender identity	___ cultural issues	___ familial conflict
___ generational conflict	___ eating problems	___ physical pain
___ sexual abuse/trauma	___ physical abuse/trauma	___ relationship stress
___ emotional abuse/trauma	___ abusive relationship (current)	___ self-harm behaviors
___ ability/disability status	___ financial concerns	___ access to housing

___ other: _____

2. Please describe how you have been feeling: _____

_____

_____

_____

3. Current sleep pattern (hours/night): _____
4. Current eating habits: _____
5. Current exercise habits: _____
6. Tobacco? Yes / No How much/day? _____
7. Alcohol? Yes / No How much? How often? _____
8. Drugs? Yes / No How much? How often? _____
9. Do you believe you have a problem with alcohol or drug use? Yes / No / Maybe

Comments: _____

_____

10. Are you presently seeing another therapist? Yes / No

If yes, provide name of provider: _____

Phone: _____ Address: _____

Fax: _____ Email: _____

Date of last visit _____

11. Are you currently receiving a prescription for psychiatric medications? Yes / No

If yes, provide name of provider: _____

Phone: _____ Address: _____

Fax: _____ Email: _____

Date of last visit _____

12. Current psychiatric medication(s): _____

_____

13. Please briefly describe your goals for treatment: _____

_____

_____

_____

Mental Health History

1. Have you ever seen a psychiatrist? Yes / No Starting at what age? _____
2. Have you been diagnosed with a mental health condition? Yes / No

If yes, please describe: _____

_____

3. Have you ever been hospitalized for a psychiatric problem? Yes / No

If yes, please describe: _____

_____

4. Have you ever attempted suicide? Yes / No

If yes, please describe: _____

_____

5. Have you had past psychotherapy/counseling experiences? Yes / No

If yes, please describe: _____

_____

_____

6. Does anyone in your family have mental illness or problems with drugs or alcohol? Yes / No

If yes, please describe: _____

Medical Information

1. Past and current medical health concerns: _____

_____

2. Do you regularly experience physical pain? If so, please explain: _____

_____

3. Current medications (non-psychiatric): _____

_____

Legal History

1. Is your reason for seeking therapy related to an accident or an injury? Yes / No

If yes, please explain: _____

2. Are you presently suing anyone or thinking of suing anyone? Yes / No

If yes, please explain: _____

Support Systems & Coping

1. From who do you primarily receive support in your life? _____

_____

_____

2. Are you satisfied with your social support system? Not at all / Somewhat / Very Much So
3. What strategies have you used to cope with or manage your current struggles/problems?

_____

_____

_____

4. Please list some of your strengths (things you are proud of): _____

_____

_____

_____

5. Is there anything else you would like me to know about at this time? _____

_____

_____

_____