

INFORMATION AND HISTORY

The following questions will provide demographic information; other questions will help us to focus during the initial interview. Please complete thoroughly.

Today's Date: _____

Name: _____

Age: _____

Street: _____

Birthdate: _____

City/State: _____ Zip: _____

Marital Status: _____

Telephone Numbers:

Circle:

Message OK?

Preferred: _____

Mobile / Home / Work

Y N

Secondary: _____

Mobile / Home / Work

Y N

Email: _____ (primarily for scheduling)

To whom will bills be sent? _____ Relationship? _____

Address & Telephone (if different than the patient's): _____

Highest Education Completed? _____

What is your current occupation/job and for how long? _____

How did you hear about me? _____

Contact in case of emergency (name & phone)? _____ Relationship? _____

Are you currently on Probation, Parole, or have any legal charges pending? ___Yes ___No

If yes, please explain: _____

Currently involved in any legal proceedings (e.g., a civil suit, divorce, custody case, bankruptcy, etc.)? ___Yes ___No

If yes, please explain: _____

Is an evaluation or participation in psychotherapy required of you by anyone (e.g., court or employer)? ___Yes ___No

If yes, by whom? _____ Why? _____

HOUSEHOLD & MISC. INFORMATION:

What is your living situation? _____

People Currently Living with You:

Name	Relationship	Age

MEDICAL INFORMATION:

Current Primary Physician: _____

City: _____ Phone: _____ Last Exam Date: _____

May I contact your primary physician to coordinate care if necessary? Yes No

If yes, please sign here to authorize: _____

Current medical problems: _____

Current medications and dosages: _____

Please list significant medical history (illnesses, operations, conditions):

MENTAL HEALTH HISTORY:

Are you currently receiving mental health or substance abuse services from any other provider? ___Yes ___No

If yes, please explain: _____

Have you received counseling, mental health, or substance abuse services in the past? ___Yes ___No

If so, please list below:

Approx. Dates	Provider or Institution Name	Reason

Have you taken medication for psychiatric reasons in the past? ___Yes ___No

If so, please list below:

Approx. Dates	Name of Medication	Reason

Have you ever had Psychological Testing? ___Yes ___No

If so, approximately when and where? _____

Has anyone in your family had, or been in treatment for a mental health or substance abuse condition? ___Yes ___No

If so, please list below:

Relation	Condition and/or Treatment

I have completed this form with information that is true and accurate to the best of my knowledge.

Signed: _____ Date: _____