# Confidential Patient Information

DRIVER'S LICENSE # _____
HEALTH INSURANCE – POLICY #, GROUP #, ID #, CARRIER NAME

_____

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years): _____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: ☐ Male ☐ Female

***Marital Status:*** ☐ Never Married ☐ Domestic Partnership ☐ Divorced ☐ Married ☐ Separated ☐ Widowed

Please list any children/age: _____

Address: _____/_____/_____/_____
(Street and Number) (City) (State) (Zip)

Home Phone: (_____)_____-_____ May we leave a message? ☐ Yes ☐ No

Mobile/Other Phone: (_____)_____-_____ May we leave a message? ☐ Yes ☐ No

E-mail: _____ May we email you? ☐ Yes ☐ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Emergency Contact (Name & Phone): _____

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
☐ No
☐ Yes If yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?
☐ No
☐ Yes If yes, please list: _____

Have you ever been prescribed psychiatric medication?
☐ No
☐ Yes If yes, please list and provide dates: _____

***GENERAL HEALTH AND MENTAL HEALTH INFORMATION:***

1. How would you rate your current physical health?
☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific health problems you are currently experiencing: _____

_____

2. How would you rate your current sleeping habits?
☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific sleep problems you are currently experiencing: _____

_____

3. How many times per week do you generally exercise? _____

What types of exercise/activities do you participate in?_____

4. Please list any difficulties you experience with your appetite or eating patterns _____

_____

5. Are you currently experiencing overwhelming sadness, grief or depression?
☐ No
☐ Yes If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
☐ No
☐ Yes If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
☐ No
☐ Yes If yes, please describe? _____

8. Do you drink alcohol more than once a week? ☐ No ☐ Yes

9. How often do you engage in recreational drug use? ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

10. Are you currently in a romantic relationship?
☐ No
☐ Yes If yes, for how long? _____
On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently: _____

_____

***FAMILY MENTAL HEALTH HISTORY:***

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

| | | | |
|---|---|---|---|
| ☐ Alcohol/Substance Abuse | | ☐ Eating Disorders | |
| ☐ Anxiety | | ☐ Obesity | |
| ☐ Depression | | ☐ Obsessive Compulsive Behavior | |
| ☐ Domestic Violence | | ☐ Suicide Attempts | |
| ☐ Schizophrenia | | ☐ Other: | |

***ADDITIONAL INFORMATION:***

1. Are you currently employed?
☐ No
☐ Yes If yes, what is your current employment situation: _____

_____

Do you enjoy your work? Is there anything stressful about your current work? _____

_____

_____

2. Do you consider yourself to be spiritual or religious?
☐ No
☐ Yes If yes, describe your faith or belief: _____

_____

3. What do you consider to be some of your strengths? _____

_____

_____

4. What do you consider to be some of your weaknesses?
_____

_____

_____

5. What would you like to accomplish with your time in therapy? _____

_____

_____

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I hereby authorize the use of this signature on all my insurance submissions, and also certify that all insurance information given to this office is correct and complete. I hereby authorize this office to release all information necessary to process my insurance claim(s) and to secure the payment of benefits.

Client Signature: _____ Date: _____

Guardian Signature: _____ Date: _____