Patient Information

Please complete all items on this form. In practice, we have found that each item has importance and will be useful to help provide the best quality of service to you. Please print or write legibly. Thank you.

Last Name of Patient	First Name	Middle Name	(Preferred Nickname)
Home Address (Please no P.O. Boxes)	City	Zip	Home Phone
Employer or School	Occupation or School Grade	Last Education Completed	Monthly Income
Business or School Address	City	Zip	Business/School Phone
Date of Birth	Age	Social Security Number	
Marital Status __ Never Married __ Married __ Separated __ Divorced __ Widowed			
Living Situation __ Alone __ Spouse/Partner __ Child(ren) __ Parent(s) __ Roommate(s)			
Children Living at Home, Including Names, Ages, and Genders			
Last Name of Spouse, Parent, or Insured	First Name	Middle Name	(Preferred Nickname)
Employer	Occupation	Last Education Completed	Monthly Income
Business Address	City	Zip	Business Phone
Date of Birth	Age	Social Security Number	
Whom may we thank for referring you?	Address		Phone Number
Whom may we contact in an emergency?	Relationship to You		Phone Number
Name of Primary Physician	Address	Phone Number	Date of Last Visit
List other professionals currently treating you and for what conditions			
List any current physical or medical problems or conditions, accidents, hospitalizations, allergies, and all prescriptions.			
Describe current and past usage of alcohol and recreational drugs.			
If you have sought psychological services before, when, why, how long, and with whom.			
Please state briefly why you seek psychological services now.			
For a minor patient, name of person who is legally responsible for care and physical custody.			

The above information is correct to the best of my knowledge. I will notify you of any changes in this information.

Signature of Person Completing This Form Printed Name Relationship to Patient Date