

PLEASE PRINT

1. Name: _____ Birth Date: _____ Age: _____

Mailing Address: _____

Street City State Zip

May we use the above address for billing & correspondence? Yes No

Phone (at which you may be reached): _____ May we leave a message? Yes No

Marital Status: Never married Now married # times married _____

Separated Divorced Widowed

Sex: male female

Social Security #: _____

2. Do you have a legal guardian? Yes No

Guardian's name: _____

address: _____ phone: _____

3. In case of emergency, whom should we contact? _____

(Name:) (Phone)

(Address) (Relationship of this person to you, e.g., parent, spouse, friend, etc.)

4. Primary insurance carrier's name & phone number? _____

5. Insured's name & ID#? _____ Birth Date: _____

6. Deductible & Co-pay information? _____

7. Secondary insurance carrier's name & phone number? _____

8. Insured's name & ID#? _____ Birth Date: _____

9. Deductible & Co-pay information? _____

10. Primary physician's name & city: _____

11. How did you learn about our practice? _____

12 Are you employed: Yes No Not applicable

If yes, how long at current position? _____

What type of job do you hold?

professional/technical	manager/administration	homemaker	sales
clerical	craftsperson	private houseworker	
farmer/farm manager	laborer	service	other

If unemployed, for how long? _____

Primary reason for unemployed status? _____

13. Have you received mental health care before? Yes No
 If yes, approximately how many different therapists have you had (not the # of appointments)? _____
 What were the approximate dates of earlier treatment(s)? _____
 Have you ever been hospitalized for a mental health concern? Yes No
 If yes, what approximate date(s) and what hospital(s)? _____
14. Have you received substance abuse/dependency (drug and/or alcohol) services? Yes No
 If yes, how many times? _____
 Ever received inpatient substance abuse treatment? Yes No
 If yes, when and what facility(ies)? _____
15. What illnesses/conditions do you have?
 asthma headaches thyroid seizures colon trouble other: _____
 pain ulcers cancer diabetes high blood pres.
 allergies, please list: _____
16. What medications do you currently take? _____

17. What surgeries have you had? _____
18. Have you ever lost consciousness? Yes No If yes, for how long? _____ What was the cause of
 the unconsciousness? _____
19. How many caffeinated drinks do you have each day (in 8 - 12 oz servings)?
 none 1-2 3-5 6-8 9 or more
20. Which of the following best describes your alcohol consumption?
 I don't drink alcohol. I drink _____ drinks per week (on average).
21. Do you currently use any other non-prescribed mind altering substances (street drugs)? Yes No
 If yes, please list: _____
 Have you used street drugs in the past? Yes No
 If yes, please list: _____
22. Have you ever thought about killing yourself? Yes No
 If yes, when? _____
 If yes, did you have a plan(s)? Yes No
 If yes, did you attempt your plan(s)? Yes No
 If yes, how many attempts? _____
 When were these attempts? _____
23. What would you like to discuss during your appointment: _____

I understand and agree that I am responsible for the charges for services provided and any balance not paid
 by my insurance policy. _____

(Patient or guardian's signature)