PATIENT INFORMATION SHEET

Today's Date______________

Patient Name____________________________________Home Phone #__________________________

Work Phone #____________________________________Cell Phone #___________________________

May I contact you or leave a message at these phone numbers?_________________________________

Address___________________________________City_____________________Zip_________________

May I send mail to you at this address?___________

Patient Age_______Birthdate___________School_________________________Grade______________

Marital Status____________

Responsible Party__________________________Address_________________________________
(if patient is a minor) (if different from patient)

Patient's Mother___________________________Address________________________________
(if minor) (if different from patient)

Occupation____

Employer_________________________________Address________________________________

Emergency Contact_________________________Rel. to patient_________Phone______________

Whom may we thank for referring this patient?____

Names & ages of family members living at home____

____

Reason for appointment____

____

____

____

Patient Name____

Please list any <u>prior</u> counseling or hospital treatment for emotional issues or substance abuse including dates____

____

____

Other professionals currently treating you for any medical or psychological condition:

____

____

Current medical conditions including serious accidents and/or illnesses:

____

____

____

Current medications, dosages including the approximate date started:

____

____

____

Please describe your use of caffeine, tobacco, alcohol and other substances.

____

____

Primary Care Physician____

Address____

Phone____

SIGNATURE____DATE___________________