

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 prior 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 _____

