

ADULT PATIENT INFORMATION FORM

Confidential Information:

Name: _____ DOB ____/____/____ Age _____

Address: _____
(Street) (City, State) (Zip code)

Phone #: Home (____)_____ Cell (____)_____ Email _____

Permission to be contacted by telephone: Yes ____ No ____ (Please specify if there is a number where you prefer to receive messages, or one where you do not wish to receive calls)

Permission to be contacted by mail: Yes ____ No ____

Current employer _____ Telephone Number: (____)_____

Job title _____ How long employed here? _____

Prior work history: (Please include title, employer, and dates of employment)

Educational history: (Please include names of institutions, dates of graduations, and types of degrees and honors for high school, university or graduate work, and any relevant occupational or trade training)

Military Service? Yes ____ No ____ Branch: _____ Rank: _____ Dates: _____

Overseas Service? Yes ____ No ____ Area: _____ Dates: _____

Combat? Yes ____ No ____

Hospitalized? Yes ____ No ____

Please specify reason for hospitalization: _____

Emergency Contact: _____ Telephone #: (____) _____

Emergency contact's relationship to you: _____

Religious/Spiritual Affiliation: _____

Family/Significant Others: (Please provide the following information regarding parents, siblings, partner or significant other, spouse, and/or children)

Name	Relationship	Birth date	Principal Occupation & Education Completed
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Relational Status: ☐ single ☐ married ☐ separated
 ☐ divorced ☐ committed relationship

If currently married, when? _____ If separated or divorced, when? _____

If married more than once, please give dates of prior marriages:

Gender Identity: _____

Sexual Orientation: _____

Race/Ethnicity: _____

Have you or your family ever consulted a mental health professional about your concerns or problems? Yes ☐ No ☐ (If yes, please indicate the name of professional(s) and year)

Primary Physician: _____ Phone: (____) _____

Address: _____

Date of last physical: _____

Have you seen your physician or nurse practitioner for any medical concerns in the past year?

Yes ☐ No ☐ If yes, briefly explain: _____

Have you ever been hospitalized for psychiatric symptoms? Yes ___ No ___ If yes, briefly explain: _____

Are you currently taking any prescribed medication(s)? Yes ___ No ___ If yes, please list the names of the medication(s) and the condition(s) for which they were prescribed:

Condition	Prescriptions/Medications	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____

Childhood History:

Were your parents ever separated? _____ If so, for how long? _____

Did your parents divorce? _____ If so, how old were you? _____

Did your parents remarry? _____ If so, how old were you? _____

Please specify custody arrangements: _____

Did you ever live with anyone other than your parents as a child? _____ If so, who and for how long? _____

Were you adopted? _____ If so, at what age? _____

Any health or other problems as a child? _____

Any specific school difficulties? _____

Please describe any other important information from your childhood: (ex. Parent medical, psychiatric or marital history, relevant sibling information, traumatic events etc.)

Referral Source: (Name) _____

May I call the referral source to thank them for the referral? Yes ____ No ____

Presenting concerns: (Please describe your main concerns)

Rate the degree of distress these concerns are currently causing you by circling the appropriate number:

1	2	3	4	5	6	7
Mild Distress						Severe Distress

How long have these concerns been causing this distress? _____

Rate your ability to cope with your current concerns:

1	2	3	4	5	6	7
Very Able to Cope						Almost Unable to Cope

What are the goals you hope to achieve in therapy? _____

Comments: (Please provide any additional information about yourself which might be helpful)

Signature and Date