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: _____
_____
_____
_____

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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: _____
_____

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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.)

_____

_____

_____

_____

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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

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