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Patient Information Form

Name____________________________________ Birthday _____________ Today's date___________

Name____________________________________ Birthday _____________

Children's Names ______________________age__________
______________________age__________
______________________age__________
______________________age__________

Address_________________________________ City__________________ zip__________________

Phone # **H ___________________ W__________________ Cell______________________________**
Is it OK to leave a message? ____________________

Occupation____________________________________ Social Security Number _______________

Employer______________________________________

If you are a student where are you attending? ____

What are your reasons for coming to counseling? ____

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Possible areas to be covered in therapy:

___abortion
___alcohol/drug problems
___behavior problems
___communication
___children/parenting
___depression/anxiety
___school difficulties
___anger
___eating disturbances
___in-law difficulties
___marriage problems
___occupational problems
___personality growth
___self image
___sexual difficulties
___social activities
___stress
___suicidal thoughts

___faith
___grief/loss
___hurts and conflicts
___infertility
___prior trauma
___unwanted pregnancy
___sexual abuse
other____

If needed would you be willing to sign a Release of Information so that we might obtain the information already gathered from your previous therapist or medical doctor? __________

Who referred you to me? ____

Are you presently taking medication (s)? If so what, how often and how much?

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Name of Physician _____________________________phone ________________________

Do you have current medical problems that may be affecting your mental health?
____

Do you belong to a church? ____

Where? ___________________________________ Pastor' name________________________

Who should I contact in an emergency? ____

Address____ phone________________________