PSYCHOTHERAPY PATIENT INFORMATION

Name:________________________________ Date of Birth:______________________ Age:____________

Address:_______________________________________ City/State:______________________ Zip:__________

Telephone(s): ____________________________________ Email: ______________________________________

Preferred Method of Communication: ☐ Phone ☐ Email ☐ Text ☐ Other (specify): _______________

Marital Status/Children:____________________________ Occupation: _________________________________

Education: ______________________________Employer/School: _____________________________________

Emergency Contacts (Names/Relation/Telephone & Address):____

____

Psychiatric History: Age of onset __________ nature of problems______________________________________

____

History of Treatment/Medications: ____

____

Family Psych. History: ____

____

History of Substance Abuse/Treatment: ____

____

Family History of Substance Abuse: ____

____

Significant Illnesses (past/present/family history): ____

____

History of Trauma: ____

____

Chief Complaint at this Time: ____

____