Name: ______________________ DOB: ____________ Date: ____________

Social Security No: ______________________ Sex: ____________ Marital Status: ________

Address: ____

City: ______________________ State: ____________ Zip: ____________

Home Phone: ______________________ Work Phone: ______________________

Email Address: ______________________ Fax No: ______________________

Employer: ______________________ Address: ______________________

School: ______________________ Address: ______________________

Emergency Contact: ______________________ Phone: ______________________

Address: ____

Nearest Relative: ______________________ Phone: ______________________

Address: ____

Referred By: ____

I will be paying by: Cash Check Credit Card

Person Responsible For Bill: ______________________ Phone: ______________________

Address: ____

Primary Insurance: ______________________ Patient Relation to Policy Holder: ____________

Policy Holder's Name: ______________________ SSN: ____________ DOB: ____________

Policy Holder's Address: ____

Insurance ID No: ______________________ Group: ______________________

Insurance Address: ____

Insurance Tel No: ______________________ Employer: ______________________

Secondary Insurance: ______________________ Patient Relation to Policy Holder: ____________

Policy Holder's Name: ______________________ SSN: ____________ DOB: ____________

Policy Holder's Address: ____

Insurance ID No: ______________________ Group: ______________________

Insurance Address: ____

Insurance Tel No: ______________________ Employer: ______________________

Name: DOB: Date:

HOW DID YOU FIND OUT ABOUT US?

Referral Source: Agency:

Telephone:

Address:

WHAT PROMPTED YOU TO CONTACT US FOR HELP?

CURRENT SYMPTOMS AND PROBLEMS (Circle any problems you have experienced in the past month.)

Depression	Unhappy with your situation	Short attention span	Hallucinations
Grief/loss	Pessimism about the future	Memory problems	Paranoid thoughts
Anxiety	Traumatic memories	Compulsive behaviors	Other unusual thoughts
Panic attacks	Nightmares	Compulsive overeating	Self-destructive behavior
Fears/phobias	Sleep disturbance	Anorexia	Suicidal urges
Obsessional worry	Appetite changes	Bulimia	Aggressive urges
Feeling helpless or trapped	Fatigue/energy problems	Alcohol abuse or dependence	Other:
Unhappy with your self	Inability concentrating	Drug abuse or dependence	

HABITS & SUBSTANCE USE

SUBSTANCE	AMOUNT USED
Tobacco products:	
Alcohol:	
Street drugs:	
Other:	

PSYCHIATRIC TREATMENT HISTORY

PSYCHIATRIST/THERAPIST/HOSPITAL	DATES
1.	
2.	
3.	
4.	
5.	

Name: DOB: Date:

ALLERGIES

1.	4.
2.	5.
3.	6.

CURRENT MEDICATION

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

MEDICAL PROBLEMS & SURGERY

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

MEDICAL CARE

Doctor	Specialty	Office/Address
1.		
2.		
3.		
4.		

REVIEW OF SYSTEMS

Headache	Glaucoma	Gastrits/Ulcer	Chronic pain
Head injury	Hearing problems	Hepatitis	Fibromyalgia
Loss of consciousness	Angina or chest pain	Irritable bowel	Bone or joint problems
Seizures	Heart attack	Other intestinal problems	Chronic fatigue
Dizziness or faintness	Heart rhythm disturbances	Kidney problems	HIV/AIDS
Numbness & tingling	Heart valve problems	Other urinary tract problems	
Weakness	Shortness of breath	Diabetes	
Coordination problems	Asthma	Thyroid problems	
High blood pressure	Tuberculosis	Menstrual problems	
Vision problems	Esophagitis/Reflux	Other hormonal problems	

Signature: **Date:**