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Patient Information Form

Today's Date: _____

Patient Name:_____

Street Address:_____

City:_____ State: _____ Zip Code:_____

Contact info: (put a star next to preferred number):

Home #:_____

Cell #:_____

Work #:_____

Email: _____

Date of Birth:_____

Gender:_____

Emergency Contact:

Name:_____ Telephone #:_____

Relationship:_____

How were you referred?_____

Primary reason for seeking therapy: _____

Any significant medical history?_____

Any issues with drugs/alcohol? _____

Have you ever been in therapy before? If so, when? _____

If client is a minor:

School:_____ Grade:_____

Parent 1 Name:_____

Parent 1 Address: _____

_____

Parent 1 Home Phone:_____ Cell Phone:_____

Parent 1 Occupation: _____Work Phone:_____

Parent 2 Name:_____

Parent 2 Address: _____

_____

Parent 2 Home Phone:_____ Cell Phone:_____

Parent 2 Occupation: _____Work Phone:_____