



Patient Information

Name _____ DOB _____

Address _____

Phone Number _____ Preferred Phone Number _____

Email Address _____

Occupation/Employment Status _____

Spouse/Guardian _____

Name

Phone Number

Emergency Contact _____

Name

Phone Number

Primary Physician _____

Name

Phone Number

How were you referred? _____

Person Financially Responsible _____

Relationship

Address _____ Phone _____

Patient/Guardian _____

Signature _____

What issues/concerns have resulted in your seeking therapy at this time? _____

Goal for psychotherapy? _____



Have you ever had the same or similar condition? ____ Yes ____ No

If yes, when and describe _____

What attempts have previously been made to resolve this issue? _____

Family history of mental health or substance abuse? ____ Yes ____ No If yes, when and describe

Regular Physical Activity/Body Work _____

Signature _____ Today's Date _____

Signature _____ Today's Date _____