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Patient Information

Today's date: ____________

Your name: _____________________

Date of birth: _____________________ Age: _____

Social Security #: __________________

Home street address: _______________________________ Apt #: _____

City: ______________________ State: _____________

Zip Code: ______________________

Cell phone: _______________ (Can you receive text messages? yes/no)

Home phone: _________________ Work phone: __________________________

Email: _______________________

Calls will be discreet, but please indicate any restrictions:

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Primary care physician's name: ____________________ Phone: ___________________

Current and/or past significant medical issues:

____

____

Current Medications:

____

____

Name of Insurance : ____

ID Number :_______________________ Plan Code/Group # ______________

Primary Subscriber:________ Date of Birth of Primary Subscriber_____________

Are you currently employed? Yes/No (circle one) Occupation: ________________

Employer: _________________ Address: ______________________________

Emergency Contact: _____________ Address: _____________________________

Telephone: ______________

Are you in a current relationship with a significant other? _____

If so, how long have you been in this relationship? ________

Are you currently married? _______

If so, how long have you been married? ___________

Do you have any children? _______

If so, please provide their name(s) and age(s):

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Please describe why you are seeking treatment at this time:

____

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Please describe any past therapy experiences you have had: (Use back if necessary)

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