

# Patient Information

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Social Security # \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Race: \_\_\_\_\_ Marital: M S W D

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Spouse: \_\_\_\_\_

How many children? \_\_\_\_\_ Names and Ages of Children: \_\_\_\_\_

Name of Nearest Relative: \_\_\_\_\_ Phone: \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

Family Medical Doctor (first and last name): \_\_\_\_\_

When healthcare professionals work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? \_\_\_\_\_

## HISTORY OF PRESENT PROBLEM:

Purpose of this appointment: \_\_\_\_\_

Have you ever had the same or a similar condition? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, when and describe: \_\_\_\_\_

## PAST HISTORY

Do you ever have: (Place a check mark by conditions that apply to you)

- |   |   |
|---|---|
| <input type="checkbox"/> Anxiety        | <input type="checkbox"/> Eating Disorder                |
| <input type="checkbox"/> Depression     | <input type="checkbox"/> Post Traumatic Stress Disorder |
| <input type="checkbox"/> Anger          | <input type="checkbox"/> Relationship Issues            |
| <input type="checkbox"/> Abuse          | <input type="checkbox"/> Other. List: _____             |
| <input type="checkbox"/> Alcoholism     | <input type="checkbox"/> Other. List: _____             |
| <input type="checkbox"/> Drug Addiction |   |

Have you had any major illness, hospitalizations or surgeries?

Have you been treated for any health condition by a physician in the last year? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, describe: \_\_\_\_\_

What medications or drugs are you taking? (List name and dosage)

Please list any other health problems you have, no matter how insignificant they may be: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**SOCIAL HISTORY:**

Do you drink alcoholic beverages? \_\_\_\_\_ If so, how much per week? \_\_\_\_\_

Do you use any tobacco products? \_\_\_\_\_ Do you smoke? \_\_\_\_\_ If so, packs per day: \_\_\_\_\_

Do you take vitamin supplements? \_\_\_\_\_ If so, please list: \_\_\_\_\_

Do you consume caffeine? \_\_\_\_\_ If so, how much per day: \_\_\_\_\_

Do you exercise? \_\_\_\_\_ If yes, what is the frequency and type of exercise? \_\_\_\_\_

Do you sleep well at night? \_\_\_\_\_ If no, why not? \_\_\_\_\_

What are your hobbies? \_\_\_\_\_

What percentage of time during the day (at home or at your job away from home) do you spend:

Under normal stress load: \_\_\_\_\_% Under considerable stress: \_\_\_\_\_% Resting or relaxed: \_\_\_\_\_%

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**FAMILY HISTORY:**

Parents:

Father: living \_\_\_ deceased \_\_\_ (check one) Current age if still living: \_\_\_\_\_ Cause of death and age at death if deceased: \_\_\_\_\_

Mother: living \_\_\_ deceased \_\_\_ (check one) Current age if still living: \_\_\_\_\_ Cause of death and age at death if deceased: \_\_\_\_\_

Check if applicable to you: \_\_\_ I am adopted \_\_\_ As an adopted child, little is known of my birth parents or family.

Do you have any family members who suffer from the same condition you do? \_\_\_\_\_ If so, please list: \_\_\_\_\_

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AUTHORIZATION AND RELEASE: I understand that I am responsible for all costs of therapy and counseling care. I also understand that if I suspend or terminate my schedule of care as determined by my treating therapist, any fees for professional services will be immediately due and payable.

**The patient/client understands and agrees to allow this healthcare office to use his/her Patient Health Information for the purposes of treatment, payment, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.**

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature Authorizing Care: \_\_\_\_\_ Date: \_\_\_\_\_