**New Patient Information**

Client Name:_____ Age:_____

Home Phone:_____ Is it ok to leave a message?: yes no

Cell Phone:_____ Is it ok to leave a message?: yes no

E-mail Address:_____ Is it ok to leave a message?: yes no

**Living Situation:**

Please identify those living in your household.

| NAME | AGE | RELATIONSHIP |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Who will be participating in therapy? _____

How were you referred to this practice?_____

**Medical Information:**

Primary Care Physician:_____

When was you last physical: _____

Are you currently prescribed any medication? If yes, please describe:

_____

_____

Medical History (Hospitalization, surgery, chronic pain):_____

_____

**Psychiatric History**

Have you ever seen a psychiatrist, counselor, or social worker in the past?

If yes, please describe:_____

_____

Have you ever been prescribed psychotropic medication? If yes, please describe:_____

_____

Have you ever experienced any of the following?: Please circle

| | | | |
|---|---|---|---|
| Suicidal Thoughts | Suicidal attempt | Homicidal Thought | Homicidal actions |
| Domestic Violence | Physical Abuse | Sexual Abuse | Neglect |
| Emotional Abuse | Sexual Assault | Human Trafficking | |

**Substance Abuse History:**

Have you ever misused or used for recreational use (currently or in the past)?: Please circle

Cigarettes Alcohol Marijuana Cocaine Street Drugs Prescription Drugs

Have you ever received treatment for substance abuse? If yes, describe:_____

_____

**Current Concerns and Reason for Treatment: _____**

**_____**

**_____**