Information Sheet

Name: ____

Date of Birth: ____________________ Social Security #: ____________________

Address: ____

City: ____________________ State: ________ Zip Code: ____________________

Phone (home): ____________________ Phone (cell): ____________________

Phone (work): ____________________ e-mail: ____________________

Emergency Contact: Name: ____________________ Phone: ____________________

Type of Insurance: ____________________ Policy #: ____________________

Referral # (if applicable): ____________________

Employer: ____

Employment Status (circle): Full Time Part Time Unemployed Retired Active Military

Primary Care Physician: ____________________ Phone: ____________________

Address: ____

Psychiatrist (if applicable): ____________________ Phone: ____________________

Address: ____

Other Therapist (if applicable): 1. ____________________ Phone: ____________________

2. ____________________ Phone: ____________________

Medical Specialist/OBGYN (if applicable): ____________________ Phone: ____________

Current Medications (list all & dosage): ______________________________

____

____

____

Any Known Drug Allergies? ____

Turn Page Over →

Previous Psychotherapy/Counseling:

With Whom?	Year Occurred	How long?
1.		
2.		
3.		
4.		

Previous Psychiatric Hospitalizations:

Where?	Year Occurred	How long?
1.		
2.		
3.		
4.		

Do you currently smoke cigarettes? **YES** **NO**

If yes, how much per day? ______________________

Do you currently drink alcohol? **YES** **NO**

If yes, how often? ______________________

If yes, how much? ______________________

Do you currently use illicit drugs? **YES** **NO**

If yes, what do you use? ______________________

If yes, how often? ______________________

If yes, how much? ______________________

Do you currently use over-the counter medications in a manner not prescribed by a physician? **YES** **NO**

If yes, what do you use? ______________________

If yes, how often? ______________________