oday's Date:

PCP:

PATIENT INFORMATION

Please list any medications/supplements you are currently taking:

Statement of issue or list any psychological or emotional issues or symptoms:

Please list any head injuries, accidents or hospitalizations including dates and any pertinent information:

2
3

Please list any medical/mental health problems with family members- e.g. diabetes, heart disease anxiety, depression, bipolar, schizophrenia:

Children? Name Birth date: Age: Sex:

☐ Yes ☐ No

Name Birth date Age Sex: Location of residence

Name Birth date Age Sex: Location of residence

Name Birth date Age Sex: Location of residence

Chose clinic because/referred to clinic by (Please check one box): ☐ Dr. ☐ Insurance plan ☐ Hospital

Other family members seen here:

FOR ADMINISTRATION ONLY

(Please get insurance card.)

Person/Agency responsible for bill: Contact person Session fee Date of intake appointment:

Patient referred to (therapist)

Income review done? Consent forms signed Insurance card copied Other data required:

Session fee $: