PATIENT'S INFORMATION

Name: _____

Phone Number: _____ Date of Birth: _____

Symptoms: _____

_____

_____

Goals for Treatment:_____

_____

_____

Are you experiencing any thoughts to hurt yourself or anyone else?: Yes [ ] No [ ]

If yes, please explain: _____

_____

_____

Marital Status : [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Marriage Date: _____ Divorce Date: _____ Remarriage Date:_____ Date Widowed: _____

Significant Other's Name and Birthdate: _____

Children's Names and Birthdates: _____

_____N

ame and Relationship of those within your home: _____

_____

_____

Current Medical Treatment: No _____ Yes _____

If yes, Explain:_____

_____

_____

Current Medications & Name of Physician(s): _____

_____

Family History of Mental Illness, including addictions: _____

_____

_____

_____

Have you ever been in an inpatient psychiatric hospital: [ ] Yes [ ] No

If yes, please explain: _____

_____

_____

Previous Psychological or psychiatric treatment (Dates, Place& Name of Clinician)_____

_____

_____

What made previous treatment successful or unsuccessful:_____

_____

_____

_____

Have you ever been treated for drug and/or alcohol concerns:_____

If yes, please explain: _____

_____

_____