	Today's Date:
Patient Name:	/
Name you like to be called:	
Street	
City	State Zipcode
Phone: Home	Cell:
Work:	<u> </u>
E-mail address:	
How may we contact you: Home preferred method)	e Cell Work Email (Select all that apply, 'P' fo
Birth date: Age	ge: Gender: Male Female
SS #	
Ethnicity: Caucasian Africa	can-American Asian Hispanic
Other	
Relationship Status: Single I	Marriedyrs Serious relationshipyrs Divorced
Relationship Status: Single! Children? Yes, ages	
Children? Yes, ages	No
Children? Yes, agesOccupation/Work:	
Children? Yes, ages  Occupation/Work:  Student? No Yes, school no	No
Children? Yes, ages  Occupation/Work:  Student? No Yes, school no	No
Children? Yes, ages  Occupation/Work:  Student? No Yes, school na  Education:	namemajor/specialization)
Children? Yes, ages  Occupation/Work:  Student? No Yes, school not generally the school not generally	namemajor/specialization)
Children? Yes, ages Occupation/Work: Student? No Yes, school na Education: (highest level of education, degree, na Financially Responsible Party (if Relationship	major/specialization)  if different from patient):  ss:
Children? Yes, ages  Occupation/Work:  Student? No Yes, school note  Education: (highest level of education, degree, note)  Financially Responsible Party (if	major/specialization)  if different from patient):

Emergency Care Information		
Primary Care Physician: Name:		
Phone:		
Address:Street		
Street		
City State		7:poods
City State May we contact your personal physician to discuss med		Zipcode issues and/or coordinate your
care?	icai oi illeulcatioli	issues and/or coordinate your
No Yes If yes, please complete/sign "Consent"	form in attached r	anor vork
10 1 es 11 yes, piease complete/sign Consent	ioiiii iii attaciieu į	Japei work.
Family and/or friends to be contacted in an emergency:		
Name:		
Relationship		Dhone:
Name:	<del></del>	i none.
Relationship		Dhone:
		rnone
Current Concerns		
	that lad way to co	als treatment/thorans, at this
Please provide a brief description of the major concerns	tilat led you to see	ek treatment/merapy at tills
time:		
Previous Psychiatrist/Therapist		
Name of clinician: Phone Number/ Treatment dates		
<del></del>		
MEDICATIONS:		
Please list all current drugs/medications, including over	-the-counter:	
Name of medication:	Dose	Dates
		<del></del>
	<del>-</del>	<del></del>
TD1 11.		
Please list any previous psychiatric drugs/medications:	_	_
Name of medication:	Dose	Dates
		<del></del>
MEDICATION ALLERGIES:		

<b>Physical Health Status</b>					
Do you have any existing medical problems or current physical symptoms of concern to you? If so, please describe.					
Please indicate any major illne	esses, accidents, and/or hospita	alizations within the last 5 years:			
Date:					
	<del>-</del> 				
<b>Health Insurance Information</b>	on				
Type:					
PPO: YesNo					
Member ID number:					
Group ID name and/or numbe	r:				
Phone:					
Address:					
Street					
City	State	Zipcode			
Pharmacy Information					
Name:					
Phone:					
Address: Street					
City	 State	Zipcode			
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